The Health Insurance System

A narrative and pictorial description

Social Security Administration
Office of Administration
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THE HEALTH INSURANCE SYSTEM

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- The Bureau of Data Processing's Division of Health Insurance Systems,
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I. Purpose

The following describes, in general, the major subsystems which make up the Health Insurance System. The overview is intended for persons interested in tracing the general information and workflow of the system. A brief general explanation of the health insurance program opens the paper to provide the reader with a background for the more specific information on the system and related operations given later. The roles of various components participating in the program are also outlined. A glossary of terms is provided at the conclusion of the paper for ease of reference.

II. Background

The 1965 Amendments to the Social Security Act provided health insurance protection for the aged, and the 1972 Amendments further extended coverage to the disabled and individuals with chronic renal disease. Known as Medicare, Health Insurance coverage consists of two parts or plans - a hospital insurance plan and a medical insurance plan (also referred to as Part A and Part B). The former provides basic protection against hospital and related post-hospital costs, and is financed through tax contributions on covered earnings. For individuals not insured under Social Security or the Railroad Retirement Board or special transitional provisions, the hospital insurance coverage may be obtained by payment of a monthly premium. The medical insurance plan covers a substantial part of the cost of physicians' services and other health services or supplies not covered under the hospital insurance plan. Part B is voluntary and financed through premiums paid by enrollees and through Federal general revenues.

Hospital insurance benefits are related to a closed time, or "benefit", period. Payments are subject to a deductible, and after a given number of covered days, also to a coinsurance amount for the balance of covered days. Inpatient hospital services, extended care services in a skilled nursing facility and home health service visits by participating providers of these services are covered for a limited number of days or visits. Payments are generally made directly to the providers. Under special circumstances payment may be made to a nonparticipating hospital or to the beneficiary for emergency services.

Medical insurance benefits are payable for physicians' services, additional home health service visits, outpatient hospital services and other medical services and supplies. Payments are generally made on a basis of reasonable charges and are generally subject to an annual deductible amount and a coinsurance amount. If the physician or supplier of medical services accepts assignment of benefits, payment is made directly to him. (About 50% of claims processed in 1973 were paid directly to physicians/suppliers.) In other cases payment is made to the beneficiary on the basis of his request for payment.

The basic responsibility for administering the health insurance program was given to the Secretary of Health, Education and Welfare and within this authority, primary program and administrative responsibility was given to SSA. Agreements are entered into with State agencies, which determine if institutions meet conditions for participating in the hospital insurance plan. SSA also enters into agreement with public or private organizations, which serve as intermediaries (for hospital insurance) or carriers (for medical insurance) to help administer the health insurance benefit claims process. These contractor organizations, using SSA coverage and claims processing guidelines, determine which services are covered, determine amounts payable and make payment to providers and beneficiaries. They also communicate utilization and benefit information to SSA, and perform related accounting and provider audit/cost settlement functions. The intermediaries and carriers also provide reviews or hearings under established procedures for individuals or organizations appealing payment amounts or denied requests for payment. (Part A appeals meeting prescribed money limitations may be carried beyond the intermediary review, to SSA and the civil court process.)

Providers who do not choose to submit claims for payment through an intermediary deal directly with the SSA component assigned responsibility for handling direct dealing provider claims, the Division of Direct Reimbursement in the Bureau of Health Insurance. This component performs the intermediary/carrier functions noted above, through a separate subsystem which interfaces with the HI system.

Within SSA, the Bureau of Health Insurance develops policies and procedures for carrying out the HI program. Through its regional offices, BHI generally oversees intermediary and carrier operations and provides liaison between intermediaries and SSA central office, field components, Regional Attorneys and State agencies.

SSA's Bureau of Data Processing (BDP) maintains the health insurance and other related master record files, handles the automated processing of Part A admission and billing notices and Part B queries and payment records, and all automatic processing for the intermediary/carrier functions of the Division of Direct Reimbursement, BHI. BDP also provides basic accounting reports for SSA and intermediary/carrier use and extensive statistical data for the Bureau of Health Insurance, the Office of Research and Statistics and the Office of the Actuary. On a monthly basis, BDP prepares informational earnings records for non-beneficiaries attaining age 65 within three months for the purpose of soliciting applications to entitle these individuals to Medicare. (If an eligible individual fails to enroll during his initial enrollment period, his SMI and voluntary HI premiums are increased.) The SSA district offices with jurisdiction over the potential beneficiary, according to his address, handle these "leads" to completion of the application and obtaining the necessary evidence to establish entitlement.

III. The Health Insurance System

A. General

The Health Insurance System consists of several subsystems which carry out the major tasks of enrollment, utilization query/reply, health insurance bill and payment record processing, premium billing and collection and health insurance master record maintenance. In addition, as by-products of the foregoing activities, statistics-gathering operations provide data bases: for provider profiles, which are used to evaluate intermediary performance, and for other statistical information on health insurance processes. Other HI operations produce and maintain microfilm and tape records of beneficiary rolls for SSA and contractor use in the daily processing of health insurance benefit claims. Intermediary and carrier operations, which initially receive and process provider notice and billing documents, have varied systems which are integrated into SSA's operations and which transmit information through telecommunications networks. Several subsystems outside the HI system perform functions closely related to the HI system operations. The most conspicuous are those handling initial health insurance enrollment, premium deduction and Master Beneficiary Record (MBR) update operations. These subsystems will be indicated in the following description at points of interface with HI subsystems where their inclusion helps in understanding workflow.

B. Enrollment

Enrollment for health insurance coverage can occur in four basic ways:

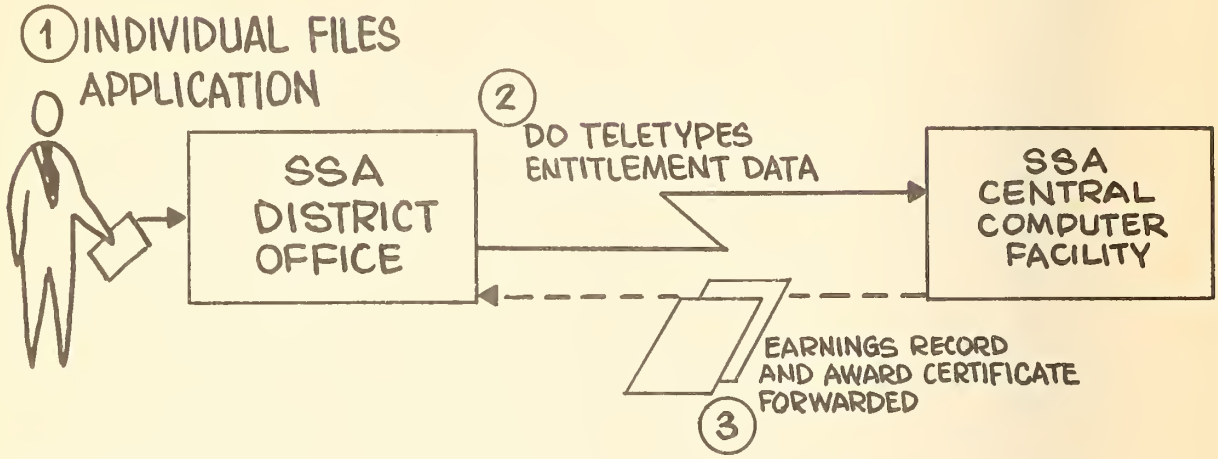
- initial application (at or after age 65)
- automatic enrollment (individual already an SSA or RRB beneficiary)
- late enrollment in a general enrollment period
- State buy-in enrollment

The SSA or RRB beneficiary who is automatically enrolled for health insurance coverage has the option to refuse medical insurance (Part B) coverage.

An eligible individual's initial enrollment period covers a continuous 7-month period beginning with the third month prior to his month of attainment of age 65. General enrollment periods are from January 1 to March 31 each year, but an individual may not enroll (and subsequently cancel coverage) more than twice, except through the State buy-in process. Disabled individuals receive health insurance protection automatically with the 25th month of entitlement to monthly social security disability benefits. (They also may decline medical insurance coverage.)

CHART 1. INITIAL APPLICATION ENROLLMENT

STEP I.



STEP II

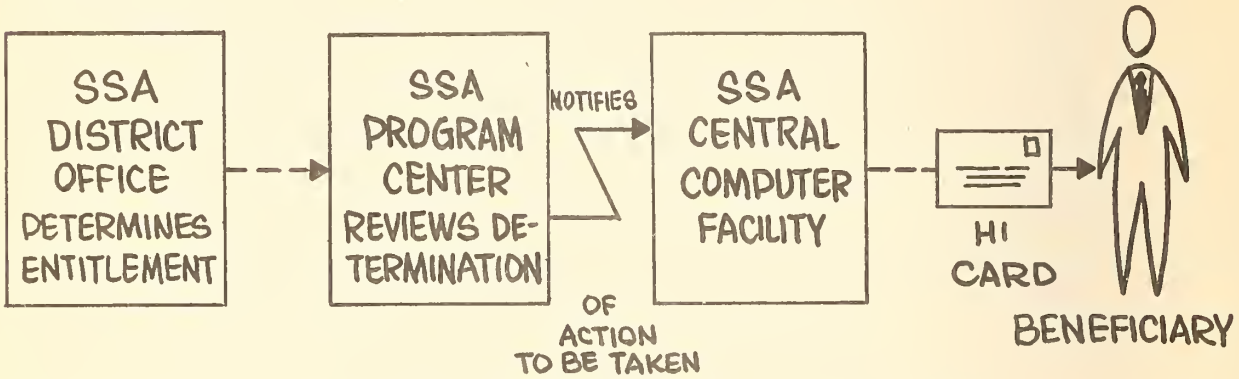
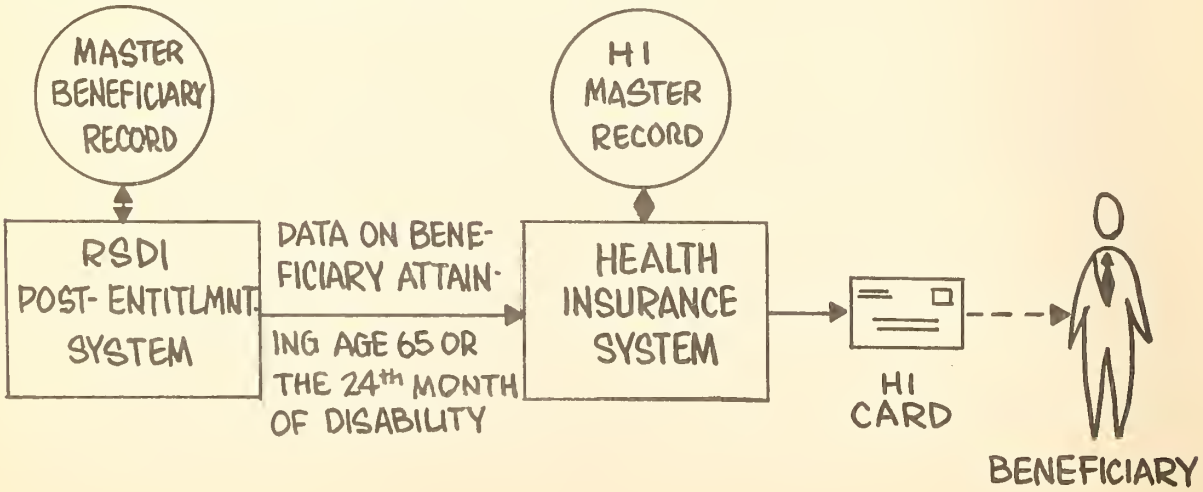


CHART 2. AUTOMATIC ENROLLMENT



In addition to social security disability beneficiaries, health insurance coverage is available to individuals with chronic kidney disease if certain eligibility requirements are met. Special entitlement dates are established for these persons.

1. Initial Application Enrollment (Chart 1)

This process establishes health insurance coverage for persons 65 or older or those with chronic renal disease. In initial enrollment cases an individual files an application in the SSA district office where pertinent information, including health insurance entitlement information, is input to the Claims Processing System.[1/] The application is processed in the servicing program center, and the individual's record is established on the Master Beneficiary Record (MBR) and the Health Insurance Master Record (HIMA).[2/] The claims system sends a notice of award of benefits and the HI system issues an HI card and prepares an address label for mailing a Medicare Handbook to the beneficiary. Establishing entitlement to Medicare is essentially a part of the claims process, even where no benefits are payable, i.e., the individual is not insured under SSA or RRB.

2. Automatic Enrollment (Chart 2)

Post-entitlement programs[3/] outside the HI system identify those beneficiaries already on the RSI rolls three months

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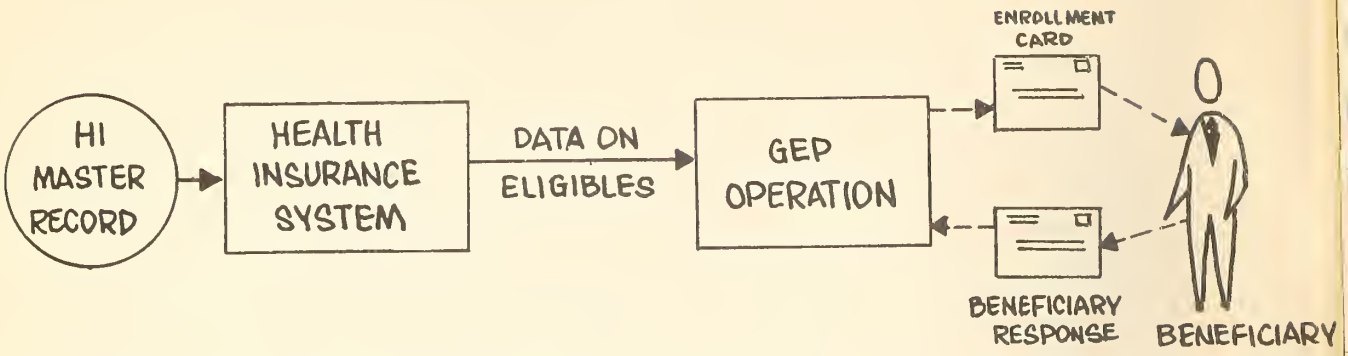
1/ This system locates earnings records, computes benefits and prepares documents for the claims file. On completion of the processing of the claim in the DO and PC, it establishes new beneficiary records and prepares transcripts for Treasury Department check printing operations.

2/ The MBR is the basic SSA file of all retirement, survivor, disability and health insurance beneficiaries. Each record has name, address and benefit information and indicators of special conditions including health insurance premium payment status. There are currently about 30 million beneficiaries on the file. The HIMA is the basic file of all individuals entitled to Part A or B benefits, or both. It has identifying information, current HI eligibility and utilization information and indicators of prior periods of entitlement. There are almost 23 1/2 million beneficiary records currently in the active file. An additional 5 1/2 million are contained in the inactive HI file.

3/ The RSDI post-entitlement system has extensive operations which update the master beneficiary record, adjust benefit (or premium) amounts, and prepare folder documentation and beneficiary notices of the action taken.

CHART 3 - GENERAL ENROLLMENT PERIOD PROCESS

STEP I - (JANUARY - MARCH EACH YEAR)



STEP II (AT CONCLUSION OF GEP OPERATION)

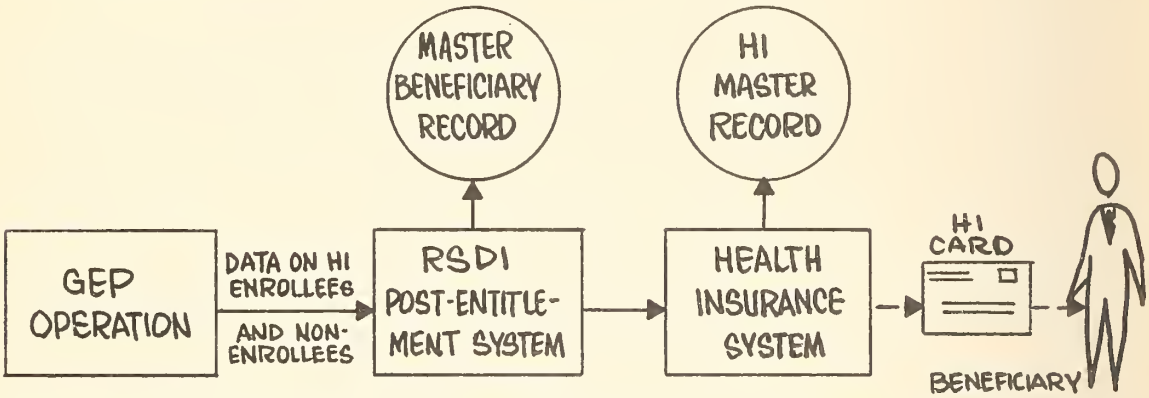
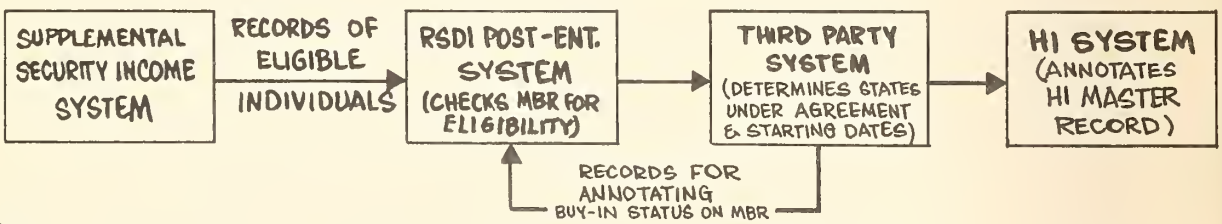
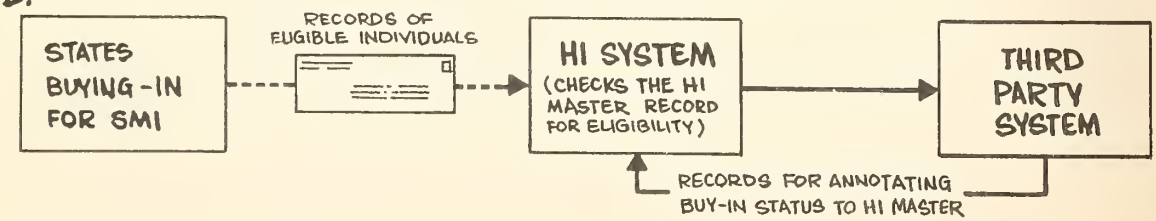


CHART 4 - STATE BUY-IN

A.



B.



prior to their attaining age 65 or when disabled for 22 continuous months, and forward their records to the health insurance update process. The latter operation establishes the HI Master record and also passes information on to the appropriate HI subsystem for the preparation of turnaround health insurance cards in the first month of the initial enrollment period. The beneficiary is notified that he is automatically enrolled and that he may decline medical insurance (Part B) coverage within 2 months after the month the notice was mailed, with no premium liability.

The Post-Entitlement System also handles the automatic deduction of premiums or directs records to the subsystem for direct billing and collection of premiums.

3. GEP Enrollment (Chart 3)

The General Enrollment Period operation handles the enrollments of those individuals who refused coverage during initial enrollment, who were terminated for failure to pay premiums or who voluntarily cancelled coverage (no more than once) for medical insurance or premium hospital insurance. The general enrollment period runs from January 1 to March 31 each year with coverage (if elected) and premium liability beginning the following July 1.

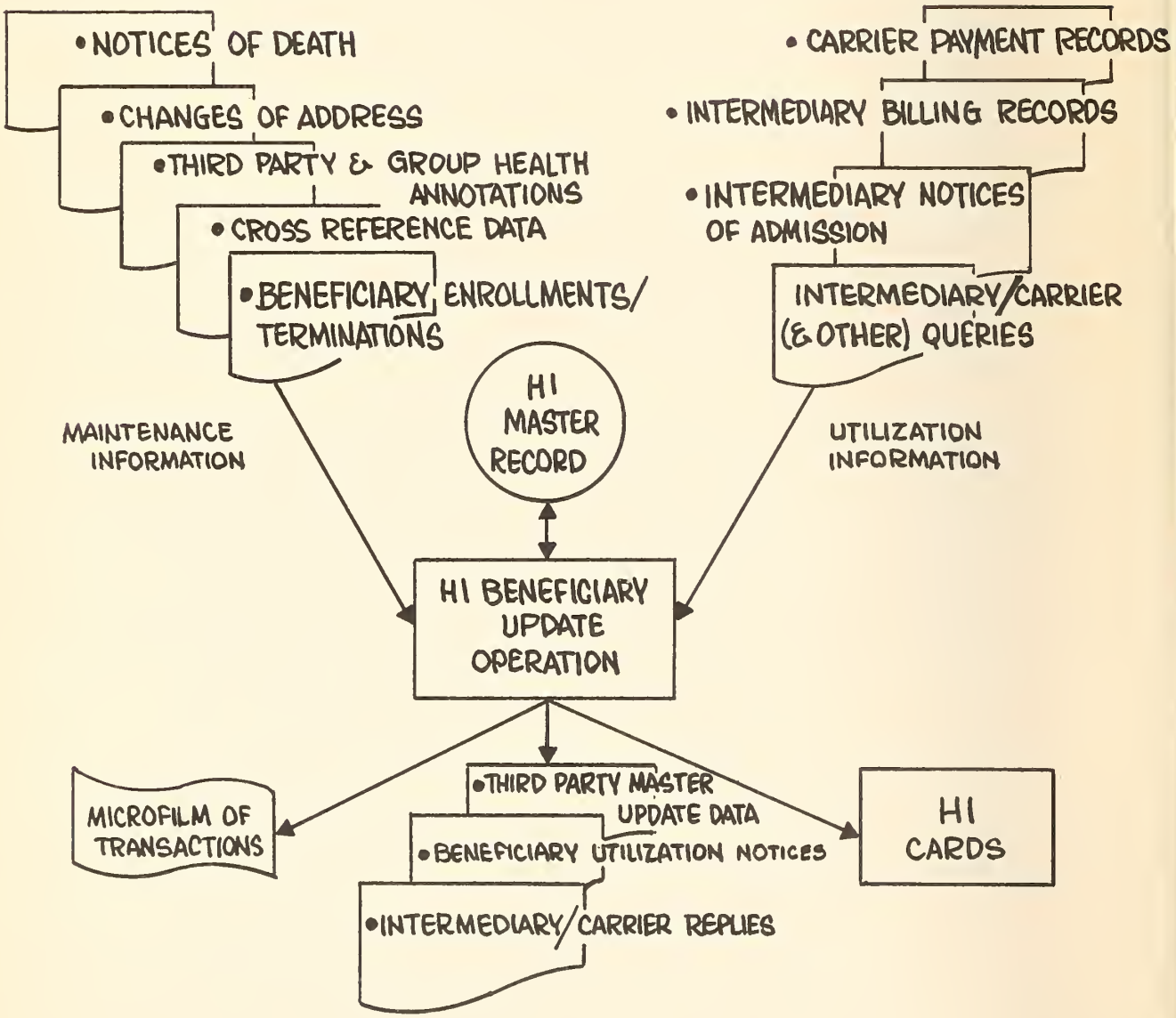
At the beginning of each GEP eligible individuals are identified in the Health Insurance Master file for the mailing of enrollment forms and informational materials. Replies, directed to either RSI program centers or central office, are applied to the GEP Master file. (This temporary file is continually updated during the GEP.) At the close of the period the final update of the GEP Master file is written off for the RSDI post-entitlement process, which updates the MBR and, as appropriate, the Billing and Collection Master record (for billing and collection of premiums).[4/] The HI Master is also updated at this time. Elections of coverage generate requests for HI cards. The GEP process also produces a microfilm record at the end of the period to provide a record of the source document (SSA-40) showing beneficiary response to contact (election, rejection or no response).

4. State Buy-In (Chart 4)

States under a "buy-in" agreement with the Department may enroll for Part B coverage persons eligible to Title XVI (Supplemental Security Income) benefits or persons eligible under State grants for medical assistance. Enrollment of an individual under State buy-in is involuntary on the individual's part; further, an enrolled person may not terminate coverage.

4/ The Billing and Collection Master file with about 6 million records contains data on beneficiaries who are not in payment status, but must be billed for premiums directly.

CHART 5: HEALTH INSURANCE MASTER BENEFICIARY RECORD MAINTENANCE



Over half the States have buy-in established based on Supplemental Security Income eligibility. In these cases SSA screens SSI eligibility records to the MBR and passes matched records to the Third Party system. Third Party determines buy-in eligibility and starting dates, bills the State and returns pertinent records to annotate the MBR and the HIMA. The remaining States submit to SSA, monthly, records of persons to be added or deleted on buy-in. After screening the HIMA for entitlement, matched records are passed to the Third Party system for processing as above. If SSA finds no entitlement record on screening, an initial application must be filed (as in item 1 above).

C. Record Maintenance (Chart 5)

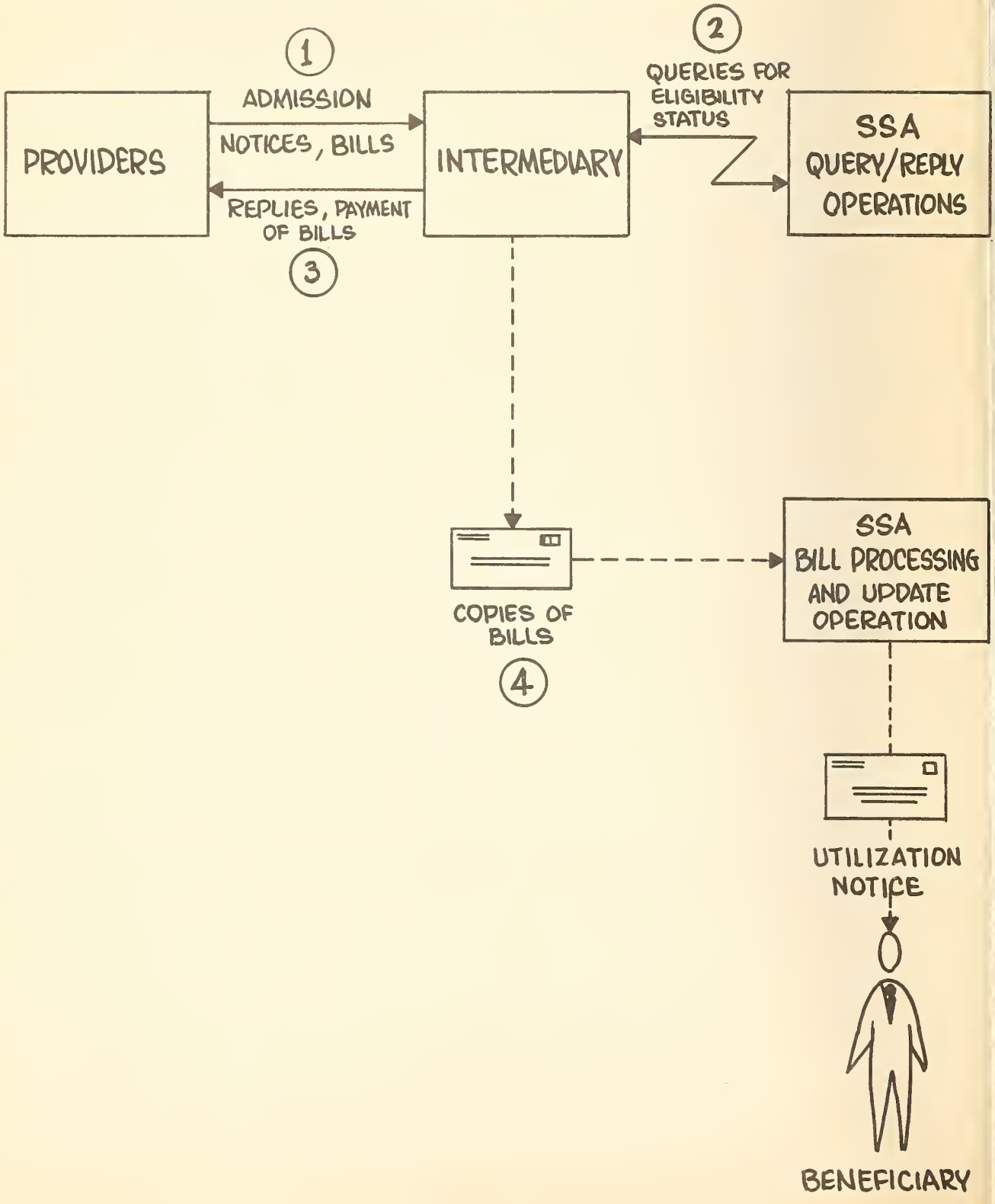
Record maintenance refers to the daily operation which keeps the Health Insurance Master record current with respect to entitlement, benefits used and still available, and other information needed for processing HI claims. The primary objective of the HI Beneficiary Master Update System, which processes changes to the HI Master, is to facilitate the providing of prompt and accurate replies to intermediary and carrier requests for beneficiary coverage and benefit status. The system controls open items and items not yet applied to the record[5/] and disperses data for subsequent processing.

Two types of information are input to the HI Beneficiary Master Update System: maintenance and utilization information. Maintenance information consists of beneficiary enrollments and terminations, cross-reference information and other changes to the beneficiary file, e.g., changes of address, notices of death, third party involvement or Group Health (Prepayment) Plan involvement. Railroad Board accretions, deletions and other changes are also input to the system (via the RSDI Post-Entitlement System). Utilization information consists of intermediary notices of admission, intermediary and carrier queries for information and billing or payment records.

Depending on the kind of input information involved, data are passed to the Update System by the Claims and Post-Entitlement Systems and other Health Insurance subsystems. Incoming information is combined, edited, reformatted (if necessary) and then matched by the Update System to the current HI Master record. The HI Master record is updated and the pending (unprocessed) and "open" items are controlled in separate record files.

5/ "Open items" are records of admission to a hospital or facility for which a discharge date has not been received or processed. "Items not yet applied" refers to queries that have passed through the edit programs but for some reason cannot be put on the HI Master record. An example would be a record "frozen" to correct some of its data.

CHART 6: HOSPITAL INSURANCE CLAIMS PROCESS



The Update System generates magnetic tapes containing intermediary and carrier query replies, utilization notices for beneficiaries, and data for updating the Third Party Master records.[6/] Tapes are also provided to the HI subsystem that generates HI cards. The operation also transmits notices of beneficiary record changes to intermediaries and carriers for correction of their records. Examples of record changes are terminations, reinstatements and cross-reference claim numbers. A history record of all transactions in a given run is microfilmed for use of SSA personnel in tracing problem cases, since the HI Master record does not carry a complete history of past actions. Magnetic tape and microfilm identification files (arranged alphabetically by beneficiary surname) are provided to intermediaries and carriers periodically for the resolution of beneficiary identification discrepancies.

D. Hospital Insurance Claims Process (Chart 6)

The hospital insurance claims process operation is essential to the objective of providing current benefit or utilization information to intermediaries. It also serves the purpose of controlling and monitoring intermediary payment to providers. When a beneficiary is hospitalized, the participating provider notifies the intermediary of the admission, which in turn transmits the information as a query to SSA to ascertain the beneficiary's eligibility status. SSA's Utilization Query and Reply Operations prepare the provider admission notices and other queries for subsequent processing in the update operations and also prepare replies (from the update) for transmitting back to intermediaries. Interim and final bills completed by hospitals, skilled nursing facilities and home health agencies are submitted to the intermediary. Based on this information and the information furnished by SSA in reply to an earlier query, the intermediary certifies payment to the provider. (The discussion of intermediary payment of "reasonable costs" to providers and of final cost settlement and audit follows in a later section.)

The intermediary batches copies of the bills (or bills recorded on magnetic tape) in groups of up to 50 and forwards them to SSA. The hard copy bills are prepared for automated processing and along with taped bill records are processed through edit and batch control operations. Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing and batch

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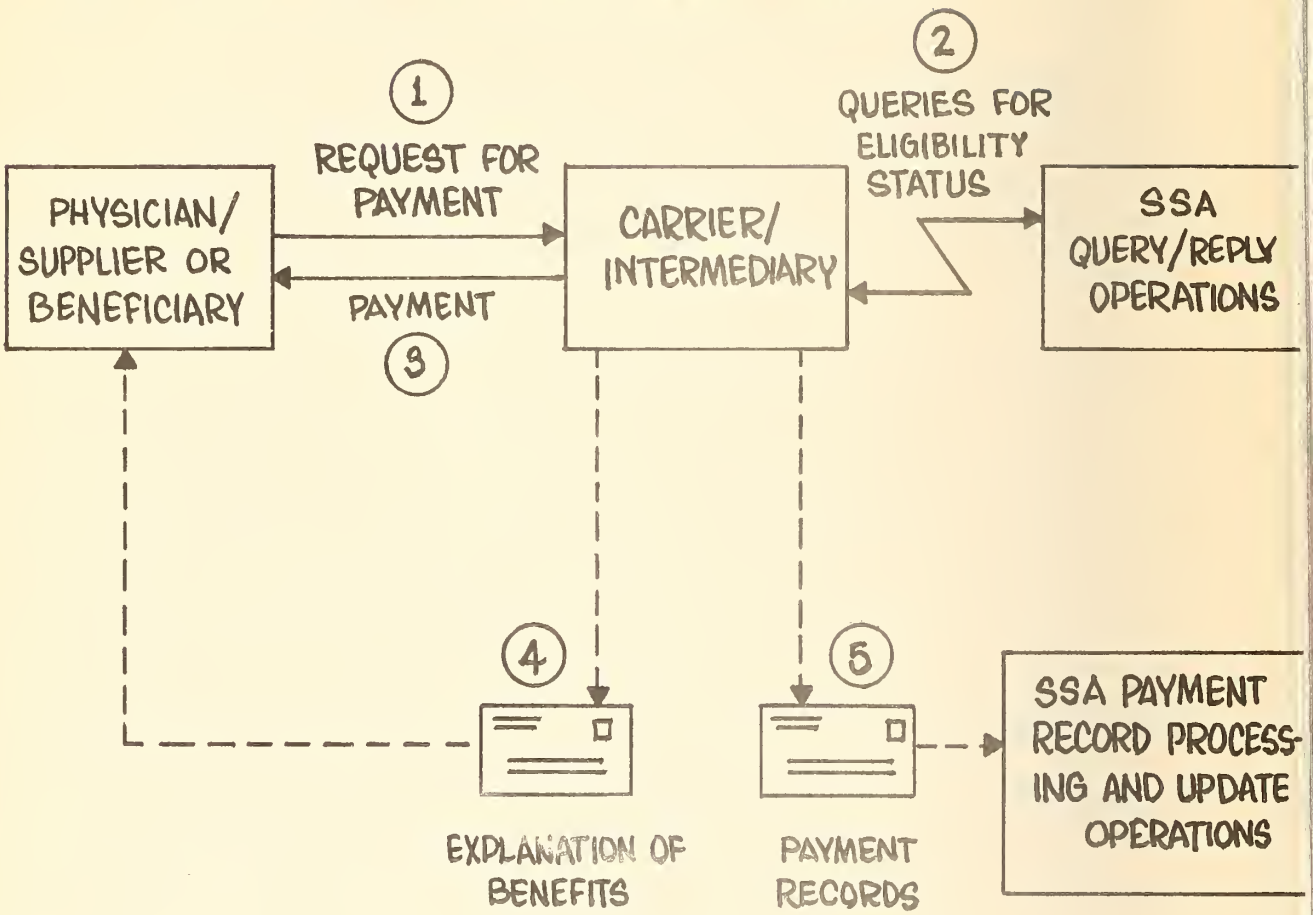
6/ The Third Party Master is the file of all HI beneficiaries whose premiums are paid by a third party: a State, the Civil Service Commission or a private organization. The file carries about 2 1/2 million individual records.

CHART 7 : MEDICAL INSURANCE CLAIMS PROCESS



completion and of outstanding returned bills are sent to intermediaries at certain intervals for their use in reconciling batches submitted and in checking on bills to be corrected and returned to SSA. (The system also prepares a microfilm record of all hard copy Part A bills submitted to SSA for clerical referencing in cases of inquiry or adjustment actions.) Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation which records the transactions on the individual's HI Master record and also generates records for updating the Provider Master File[7/] and a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice where an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on strict "in sequence" basis. That is, provider bills will be processed in "from" date sequence within a benefit period. A bill not related to a preceding open item (admission) will not be processed until the final bill for that open item is processed. All unprocessed bills are controlled, or placed in orbit, and any determination of a benefit period takes these unprocessed items into account, along with already processed, or recorded, items. (The HI Master record carries up to 5 of the most recent benefit periods in the beneficiary's record.) SSA's reply to an intermediary admission notice or query shows benefit days remaining and deductibles to be met as of the last recorded date of discharge or as of the last action, where there is an open item and interim billing has been received.

During SSA's bills processing operation a sample of bills is selected for medical coding for statistical purposes. Section H covers some of the statistical reports generated.

E. Medical Insurance Claims Process (Chart 7)

A separate SSA subsystem receives, edits and controls Part B outpatient bills and medical payment records. Processing differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy, psychiatric services and home health visits have an annual limitation on benefits payable. Part B payment records, therefore, do not update the HI Master record.

7/ The Provider Master file contains bill charges and reimbursements arranged by provider. The file is used to prepare reports for use by intermediaries in cost and audit functions.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or suppliers of the services (e.g., physicians). Where the carrier or intermediary queries SSA on the beneficiary's deductible status, the utilization query/reply operations handle the transaction similarly to Part A outpatient queries. (Part B queries update the Part B deductible, and record physical therapy and psychiatric expenses.) Taking into account the beneficiary's deductible status, the carrier or intermediary determines and makes payment to the claimant. (Carrier determinations of "reasonable charges" will be covered in a later section.) For all claims for which payment is made, payment records must be prepared. They are batched and transmitted to SSA where they are edited, then matched against the HI Master record to check for beneficiary entitlement and, if appropriate, to record physical therapy, psychiatric, or home health services. A listing of rejected records is returned to carriers or intermediaries for corrections and the records are held, in the meantime, in a suspense record file. As records are corrected and returned, they are deleted from the suspense file. In addition, another operation controls the batches of payment records and provides statistical reports on bill processing by carrier/intermediary.

Carriers submit to SSA monthly reports of monies paid during the month for HI medical services. Batches of payment records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance SSA's reimbursement to them for Part B payments made.

F. Premium Collection/Deduction

Premiums for medical insurance (Part B) are collected by two basic means: by deduction from monthly benefits and by billing for payment. Individuals paying premiums by direct remittance may elect to have premiums paid by a third party under a group billing arrangement. The Railroad Retirement Board collects premiums for all individuals entitled under the RRB program, even where they are also entitled under Social Security.

Premiums must be deducted from monthly benefits or annuities where the enrolled person is receiving Social Security or Railroad Board benefits or a Civil Service annuity. An exception to this provision is the individual covered by a State buy-in agreement, where premiums are paid by the State.

CHART 8: SMI PREMIUM DEDUCTION

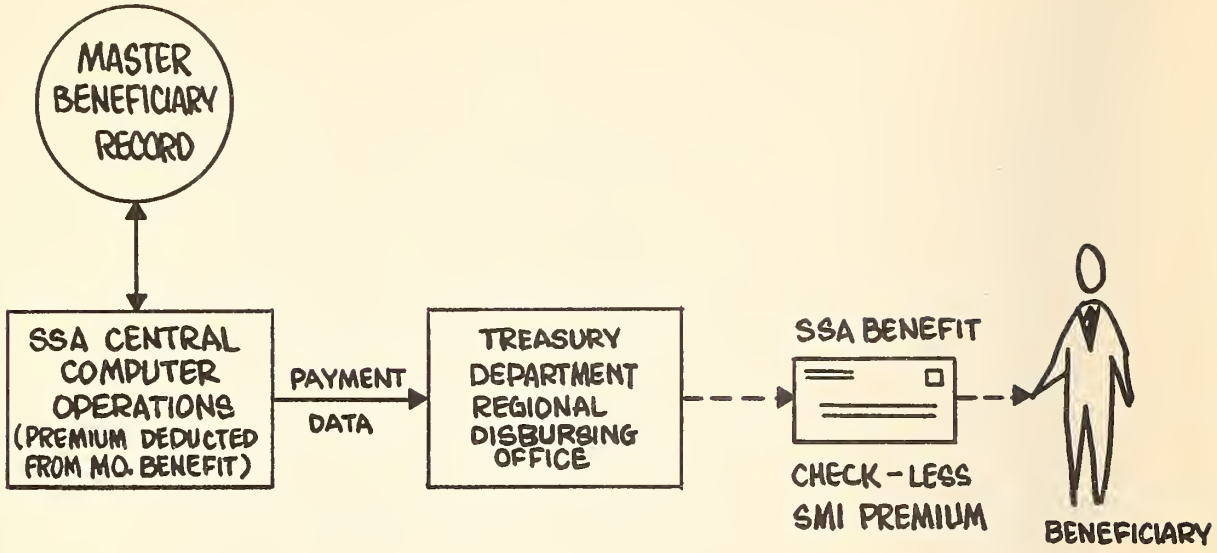
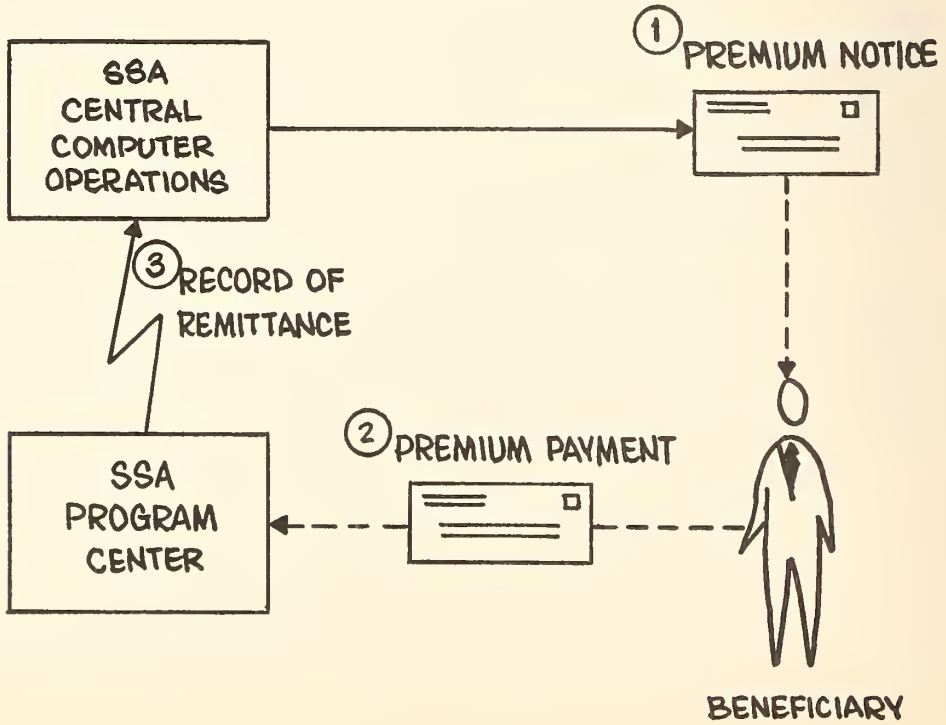


CHART 9: PREMIUM BILLING AND COLLECTION



1. Part B Premium Deduction (Chart 8)

The operation which updates the Master Beneficiary Record (MBR) and provides the Treasury Department with update files for their benefit payment operations, automatically withholds premiums from the monthly benefits due beneficiaries. Where a monthly benefit payment is deferred but will be resumed later in the year, the premium amount is accrued monthly to the beneficiary's Master record and the total amount due deducted from the first benefit check payable. In other deferred cases, where no benefits are payable for the year, the beneficiary is billed for premium payment.

2. Part A and Part B Premium Billing and Collection (Chart 9)

The Separate Operation for Billing, Entitlement and Remittances (SOBER) maintains the Billing and Collection Master (BCM) record of covered individuals who are not in benefit payment status and do not have a third party payer. (There are currently about 1 1/4 million individuals being billed for premiums.) The post-entitlement system passes all appropriate accretions, terminations or other pertinent changes to the individual's Master Beneficiary Record to the SOBER system for updating the BCM record. Premium billing notices are then generated and mailed to beneficiaries (from central office). Beneficiaries return remittances to the program centers, where input of the transaction is prepared for the SOBER system. These transactions are fed to the SOBER update operation to prepare the master record (BCM) for the next billing operation.

The SOBER system also refunds overpaid premiums on a quarterly basis, identifies individuals subject to termination because of nonpayment of premiums and passes termination information to the Health Insurance System Update operations. SOBER also provides information, when requested, on an individual's premium status. (District office and other SSA personnel handling beneficiary health insurance inquiries and problems frequently query the BCM.) A history record of all transactions is also maintained by the system, since the BCM shows only the latest updated action.

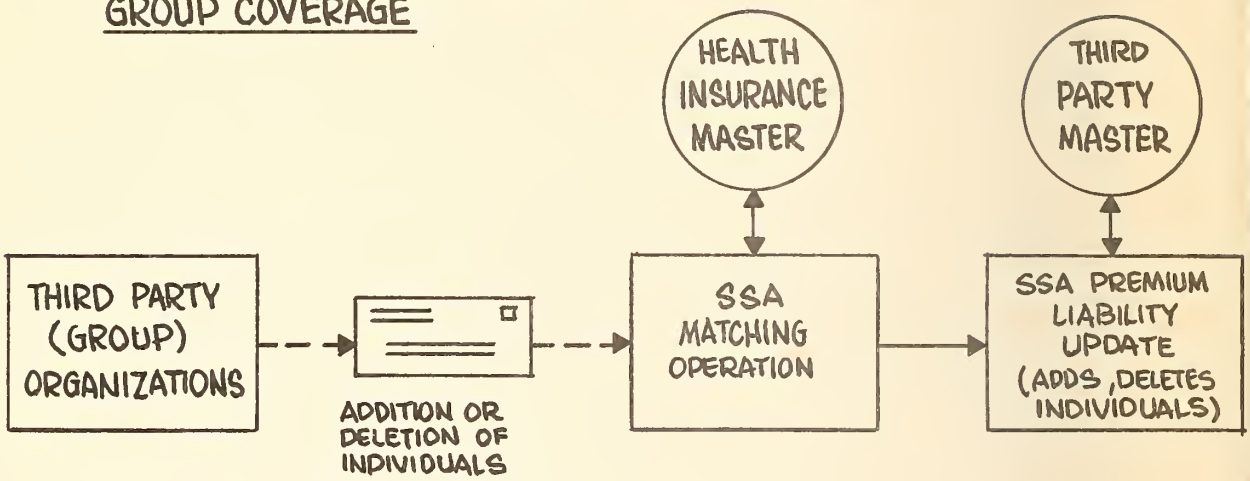
3. Group (Third Party) Premium Billing and Collection (Chart 10)

The premiums of individuals subject to direct billing may be billed for and paid by an organization which has arranged to remit for a number (usually 100 or more) of enrollees. In addition, States under a "buy-in" agreement with the Department pay premiums for eligible individuals.

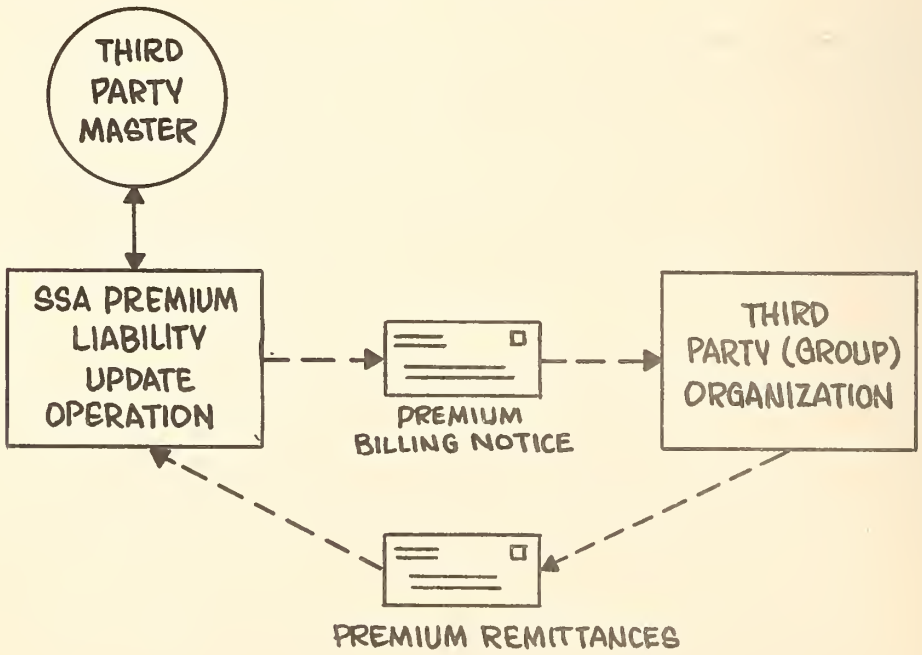
The records of over 2 1/2 million individuals whose premiums are paid by a third party organization are contained on a separate master file maintained by the Third Party Billing

CHART 10: GROUP(THIRD PARTY) PREMIUM BILLING AND COLLECTION

STEP I. ADDITION OR DELETION OF INDIVIDUALS TO/FROM GROUP COVERAGE



STEP II. BILLING AND COLLECTION OF PREMIUMS



operation. Group paying organizations submit listings, punched card, or taped records each month to the Bureau of Data Processing, adding or deleting individuals covered under the agreement. Where the individual is entitled to Medicare and becomes entitled to Supplemental Security Income benefits, SSA, for several States, automatically adds the record to State buy-in rolls.

The Third Party Master file is updated monthly and the MBR and BCM records are also adjusted to discontinue premium deduction or direct (individual) billing on the individuals' records. Incoming accretion records are screened for eligibility against the Health Insurance Master record and are then passed to the third party premium billing operation. Buy-in billing cards and listings of billing records are prepared and mailed to group payer organizations. Notices are also generated and mailed to beneficiaries to inform them of the effective date of the payment by the third party organization. Remittances from third party payers are mailed to the Bureau of Data Processing and are handled manually.

G. Group Health Plan System

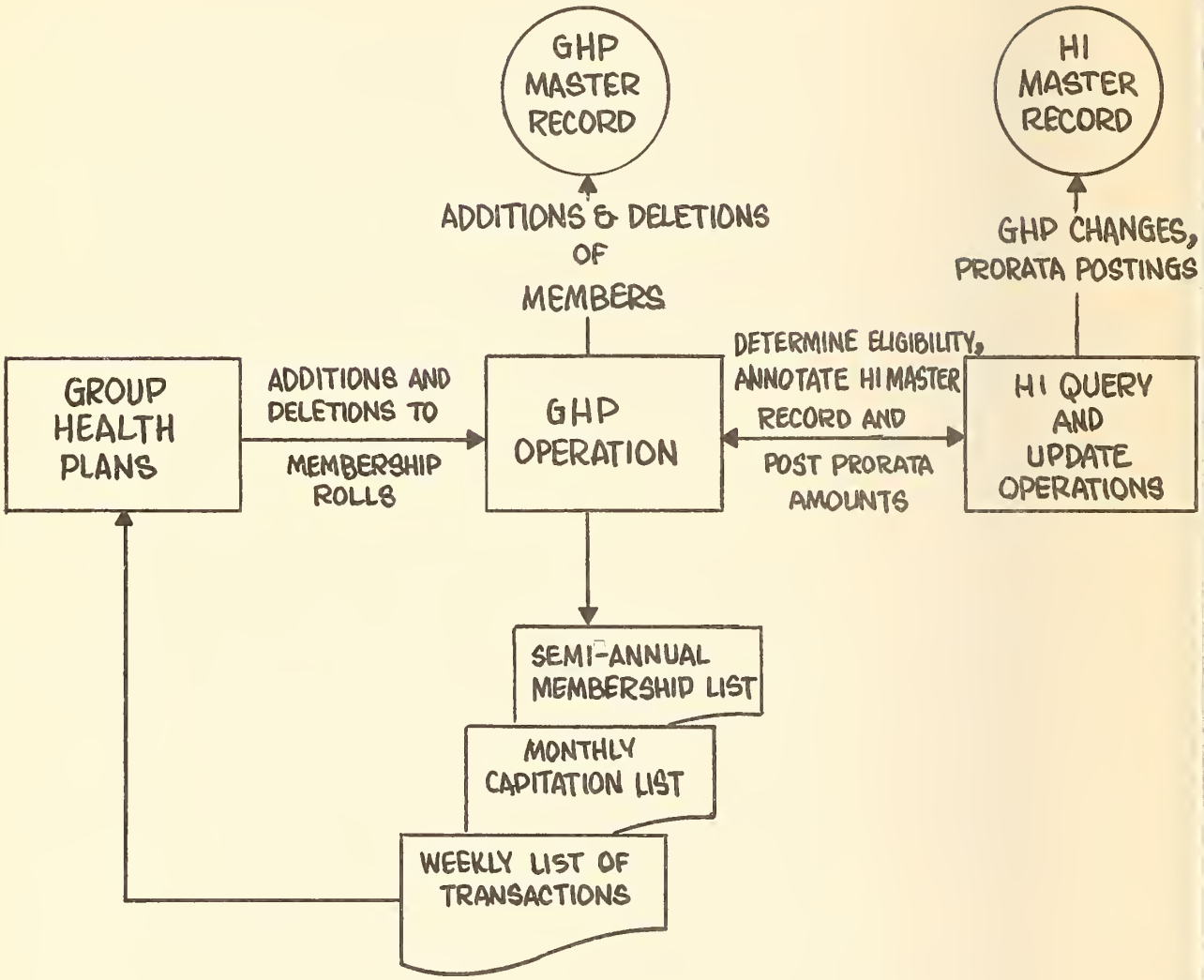
1. General

Group Health Plans as used in this paper are defined as organizations which provide members health services on a non-fee-for-service basis. Members pay toward costs through premiums paid to the plan. In order to encourage more efficient health care delivery at lower costs, the 1965 Amendments provided reimbursement to Group Practice Prepayment Plans (GPPP's) for Part B services furnished to enrollees eligible for Medicare. The 1972 Amendments extended reimbursement to Health Maintenance Organizations (HMO's) for both Part A and Part B services. As of August 1974 no HMO's have been approved for participation in the program.

Group Practice Prepayment Plans may deal directly with SSA for reimbursement on a reasonable cost basis or they may submit payment requests through carriers for reimbursement on a reasonable charge-related-to-cost basis.[8/] Currently a little under half of participating GPPP's are reimbursed directly by SSA. These direct dealing plans are paid each month on an interim, per capita basis, the fee based on estimated costs and enrollment. SSA adjusts the reimbursement after close of the plan's accounting year when the plan has filed a final cost report and DHEW completes its audit of the plan's costs records. (Here, SSA's intermediary function differs from that of non-government organizations. The latter audit provider cost records or subcontract with private audit firms to perform the audit.)

8/ The average reasonable charge determined for a plan must be related to the plan's actual cost for the service rendered.

CHART 11: GROUP HEALTH PLAN OPERATION



Carrier-dealing GPPP's establish "charges" for reimbursement of services by using historic cost figures that have been adjusted for estimated changes anticipated in utilization of services and in membership enrollment. These "charges" are subject to the carrier's approval and subsequent review of actual cost and membership records.

Health Maintenance Organizations (HMO's) may choose to be reimbursed on either an incentive or a reasonable cost basis. In the case of the former, payment will be made on a predetermined per capita basis for members eligible for Medicare benefits, with any savings realized at year end to be shared with the government (losses would be absorbed by the HMO). HMO reimbursement on a reasonable cost basis would be handled similarly to the reimbursement of GPPP's (i.e., they are paid each month on an interim, per capita basis, the fee based on estimated costs for service and enrollment. Adjustment would be made after the close of the HMO fiscal year.)

GHP members may receive medical services outside of their plans. In order to determine the beneficiary's SMI deductible status for reimbursement of these outside services, SSA posts pro-rata credits to enrollee HI Master records. (A part of an individual's GHP premium is apportioned to cover his Medicare Part B deductible.) The GHP's, with SSA approval, determine the amount of the pro-rata credit prior to each calendar year. The credit is based on the estimated occurrence and cost of services.

2. The System (Chart 11)

The GHP system maintains a master file of group health plan members for purposes of reimbursement and the control of posting pro-rata amounts to the HI records of group health plan members. Group health plans notify SSA, usually on a monthly basis, of new members to be added to the membership roll or of terminations to be deleted from the roll. The GHP operation passes records of these changes to the HI Master record for checking eligibility to health insurance. (The matched records are also passed to the HI Master beneficiary update operation to annotate the HI Master with the GHP membership.) Once eligibility is confirmed, the GHP operation records the changes on the GHP Master file. On a weekly basis, the operation prepares a listing of all transactions submitted by each plan, indicating those accepted, rejected or held pending for future processing. The listing is mailed to the plans for reconciling (or adjusting) member records.

On a monthly basis, the operation prepares capitation reports for the GHP's and appropriate BHI components for use in the reimbursement process. The report gives an opening pending, the month's additions and deletions and a closing pending.

The interim per member payment to GHP's is handled manually by BHI. Twice each year the plans are also provided with informational listings of their entire membership rolls which show the status of members on the current SSA GHP Master file.

Once a month the GHP system sends a tape record of active members to the HI Master file update operation which posts pro-rata credits to the member's HI Master record. Any changes to GHP member records noted in the HI Master file (e.g., death terminations, name or number changes or Part B terminations) are relayed back to the GHP system for updating of the GHP Master record. These items are shown on the weekly listing of transactions provided to the plans.

H. Statistics

Many of the health insurance subsystems generate statistical records relating to the particular activity of the subsystem. Most give weekly or monthly record counts of the pertinent activity file (or of exceptions from the process). The reports prepared from the statistics are used for the ongoing management of the given activity.

The major HI statistical reports that are prepared (using data from the HI system) are outlined below:

1. Beneficiary Utilization Reports

Routine and special reports and analyses of covered health services used by the aged and disabled are published periodically. For each type of service (e.g., inpatient, outpatient, SNF) detailed information such as the number of admissions and discharges, length of stay, number and rate of surgical procedures, charges for services, etc. is given. Information is also provided on medical services utilization, such as the number and rate of physicians' services, nature of treatment, etc. Demographic characteristics and geographic variations in services used are also reported periodically.

2. Provider Characteristics Reports

Periodic and special reports, tabulations and listings are generated on the characteristics of participating providers, on the variations in or between geographic areas in distribution of facilities, in services offered and availability of skilled technical personnel, and on health care facilities' performance relating to the conditions of participation.

3. Utilization Review

Medicare Analysis of Days of Care (MADOC) - Semi-annually an analysis of the performance of hospitals with respect to length of stay is provided to short-stay hospitals participating in the program. The actual length of stay in hospitals in a geographic area is compared to an "expected" average length of stay, taking into account hospital characteristics and the nature of treatment that affect the length of stay.

4. Provider Statistical and Reimbursement Report (PS&R)

The PS&R report, prepared biannually and forwarded to intermediaries for use in reconciling provider cost reports,[9/] is based on data in the Provider Master file. This file of about 24,000 individual provider records contains provider identification information, obtained from State certification records of the facility, and charge and reimbursement information obtained from billing transactions that intermediaries submit to SSA.

The report, prepared for each provider participating in the program, breaks Medicare charges and reimbursement information into four groupings: accepted bills, returned (to intermediary) bills, pending bills and total bills. Data from the current and three preceding fiscal years are shown.

5. Provider Monitor Listings

On a quarterly basis, reports ranking providers by amount of charges are prepared for BHI central and regional office use in detecting abnormal charge situations. From the Provider Master record, four sets of provider monitor listings are prepared, ranking hospitals and skilled nursing facilities in descending order of charges (per unit) submitted:

a. National ranking by category of service (e.g., physical therapy), by type of facility and bed capacity (ranked in order of highest per diem rate),

b. Comparative ranking by type of hospital (or SNF) and bed capacity (showing ranking in each category of service),

c. Comparative ranking as in b., broken out by regions,

d. Comparative ranking as in b., broken out by intermediary.

9/ The description of the provider cost settlement procedure follows in Section J, below.

Home health agencies are also ranked by category of service and are broken down by region. A second listing gives a composite ranking arranged by type of facility, then by category of service, broken down by region and by intermediary.

6. Other Statistical Reports

a. A 0.1 percent sample from the Health Insurance Master file provides, on a monthly basis, record counts for use by the Office of the Actuary in preparing reports on current beneficiaries by type of coverage.(Part B carriers are required to submit the actual bills received from beneficiaries in the 0.1% sample.)

b. Several reports on the processing of Part B payment records are prepared and sent to carriers. A monthly Carrier Experience Report on workloads shows the number of records received, processed and pending on a national, regional and carrier basis.

c. Carriers are also provided a Reasonable Charge and Denial Activity Report by national, regional and carrier breakouts. This report gives ratios of reduced and denied claims to total claims and the dollar amounts of all covered charges, reductions and disallowances. (This information is supplied by carriers in reports submitted to SSA.)

d. Statistical reports on billing or payment records returned for correction and on the status of batches of records submitted to SSA are also sent to intermediaries or carriers. The operations producing the above reports are appended to the rejected provider bill control and payment record batch control subsystems.

e. The Office of Research and Statistics reports regularly on hospital and medical benefit claims approved and amounts reimbursed. The information is included in ORS's Monthly Benefit Statistics Report on Summary Program Data, disseminated to an extensive audience. These data are periodically reported by State and county as well as for the total population. Health insurance enrollment data are also published on an annual basis: State and county breakdowns are given as well as national totals. Periodically, special data are published on State Buy-In and Group Practice Prepayment Plan enrollments.

I. Intermediary/Carrier Operations

The 98 intermediaries and 64 carriers administering the health insurance benefit payment process have differing systems, involving

varying degrees of automation, to handle the tasks of querying SSA records, forwarding eligibility or utilization information to providers, determining provider reasonable costs or charges and making payments to providers. They also must submit benefit billing or payment record information to SSA and maintain adequate records to permit SSA's periodic review of their operations.

1. Provider Reimbursement

Intermediaries reimburse providers, usually monthly, on the basis of an interim rate. Depending on the type of service rendered (e.g., inpatient hospital or home health visits), the rate is determined as a percent of the billed charges or as the average per diem cost based on the estimated reasonable cost of services. The rate may be adjusted at any time during the provider accounting year by either the provider (with intermediary approval) or the intermediary. The intermediary is required to review interim rates periodically with the aim of approximating as closely as possible the actual costs of covered services provided to Medicare beneficiaries.

Participating hospitals, skilled nursing facilities and home health agencies over a certain size and meeting certain record keeping/accounting criteria may request intermediaries to make payment under the periodic interim payment (PIP) method. Payments are generally made on a weekly basis, which provides the institution with funds shortly after providing services. The intermediary determines the amount of payment based on a per-inpatient-day figure (for hospitals and SNF's) representing the estimated costs for covered services. The intermediary must recompute the PIP rate at least quarterly, to hold payments as close as possible to actual costs incurred. Under either interim payment method intermediaries adjust payments after the annual cost reports have been filed by the providers. (Provider cost reports are discussed in Section J., below.)

Carriers generally reimburse physicians/suppliers of medical services directly, or indirectly through payment to beneficiaries, on a fee-for-service basis. They determine whether services are covered and also determine the reasonable charges for the covered services using two basic criteria provided by the law:

a) The customary charge for the service in question made by the physician or supplier furnishing the service, and

b) the prevailing charge for the service among providers in the locality in which provided.

The actual charge is reimbursed if lower than the reasonable charge.

Requests for payment (claims) sent to the carrier by beneficiaries or physicians/suppliers are reviewed to assure that the treatment shown on the billing form is consistent with the stated diagnosis or illness. Qualified claims examining personnel review questionable items and reconcile inconsistencies. After the Part B deductible is met ($60 in 1973-74) payment is generally computed as 80 percent of the reasonable charge determined by the carrier. (Hospital-based physicians, radiologists, pathologists and independent laboratories have payment calculated differently; 100 percent of inpatient services.)

2. Intermediary/Carrier Fiscal Reports

SSA reimburses carriers/intermediaries for their reasonable costs in administering the health insurance program. The latter are required, in this connection, to submit an annual estimate of costs for administrative functions and also an initial budget and subsequent quarterly (cumulative) budgets to support the estimate. Carriers and intermediaries also send SSA monthly and quarterly cost reports comparing actual expenditures with budget figures. On a fiscal year basis, they submit a final administrative cost proposal and cost classification report. SSA reviews the budget and expenditure reports and at the end of the fiscal year the DHEW Audit Agency audits intermediary and carrier accounts soon after receipt of the final cost proposal.

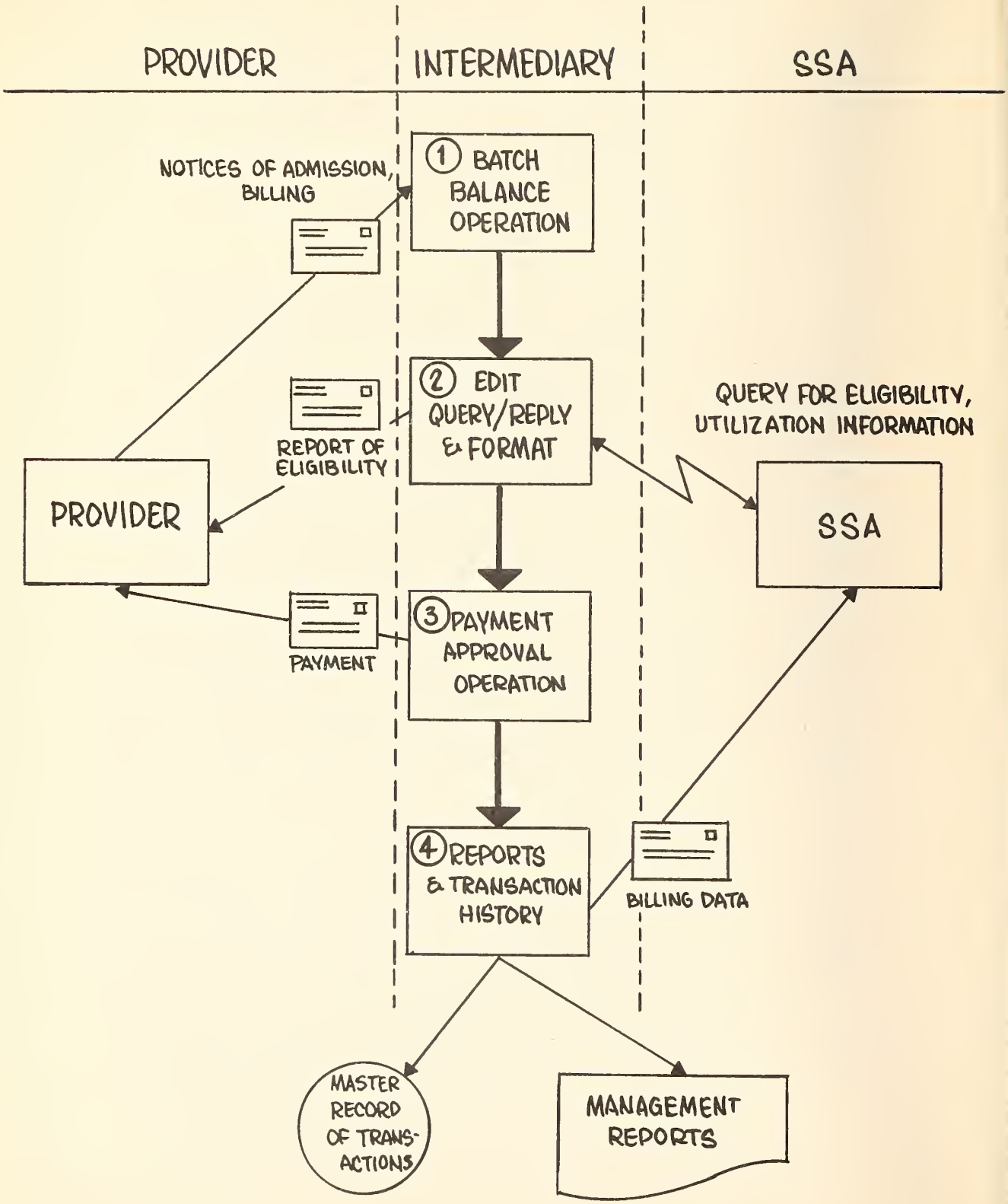
As noted in the foregoing section on SSA payment record processing, SSA reconciles its accounts on a monthly basis with those of the intermediaries and carriers. To carry out this operation, the latter provide SSA with a monthly financial data report, showing bills processed, paid or adjusted, funds expended, and an analysis of the organization's bank account.

3. Other Intermediary Responsibilities

Intermediaries handling Part A benefits process and audit provider cost reports and act in a consulting capacity to providers in setting up and maintaining provider fiscal records. They also have primary responsibility for helping providers with utilization safeguards.

Both intermediaries and carriers are required to provide adequate checks in their systems for identifying duplication and fraud in the payment process. Fraud cases are referred to the HI regional office for development. In cases of program abuse, intermediaries and carriers are responsible for correcting aberrant situations and for determining the amounts of overpayment and recovering such amounts.

CHART 12: PART A MODEL SYSTEM



4. Part A Model System (Chart 12)

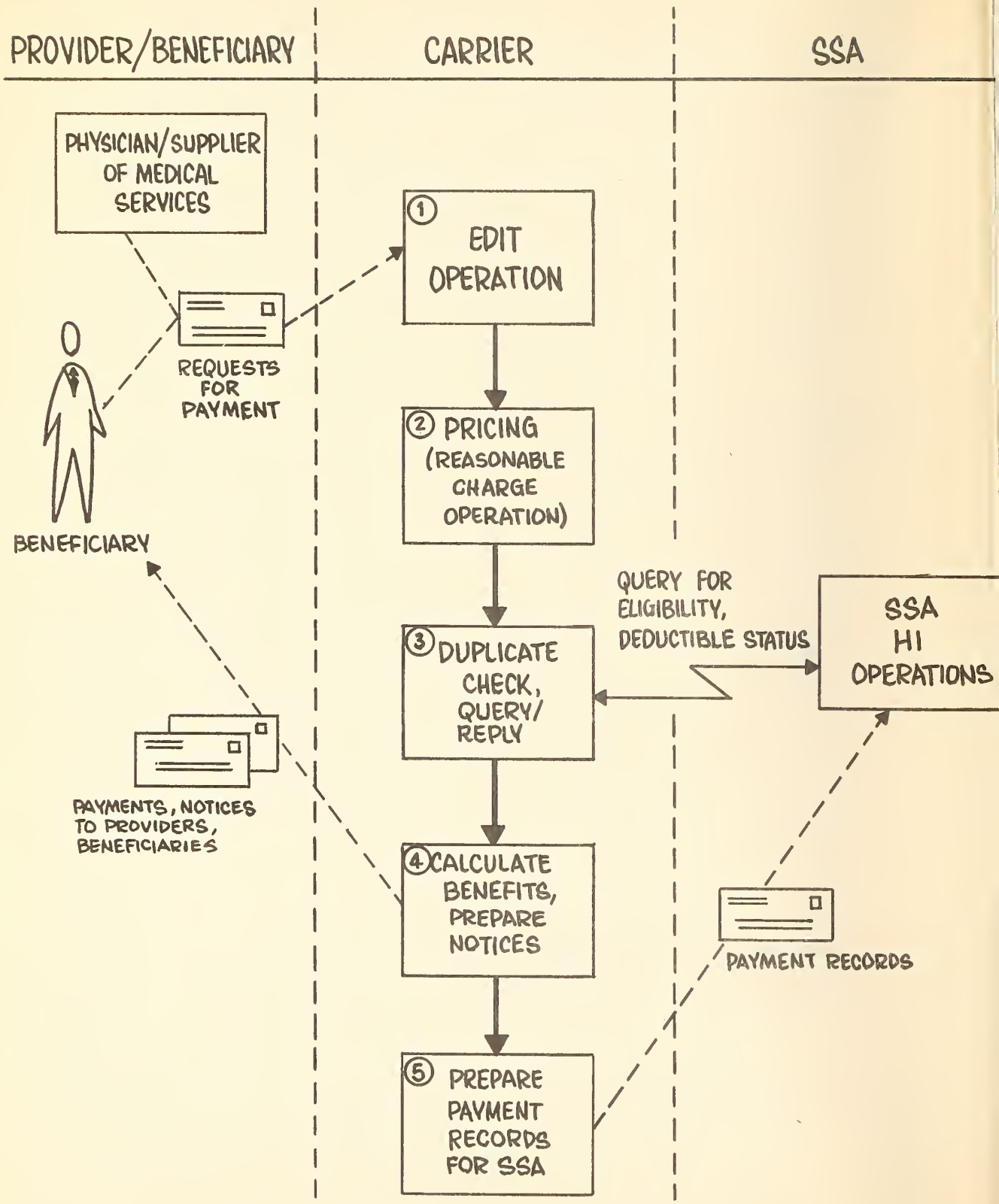
Blue Cross Association Plans serving as SSA intermediaries process the bulk of Medicare Part A requests for payment of HI benefits (almost 90 percent). The Model A system, described below to illustrate the intermediary operation, is used by about 30 percent of the Blue Cross plans. The balance use part of the system or other systems configurations for carrying out intermediary tasks. The basic model provides a standardized package with options offered to tailor it to the individual plan's computer capability. The model is also designed for use of smaller organizations through the computer of a larger plan. Four participating plans can operate through one processing plan. Data for the five plans will be combined on master files but reports generated for each plan separately.

The intermediary batches notices of admission forwarded by providers and enters them into the system. A balancing operation sets up a control, and passes accepted records on for edit; then query reformat programs prepare them for transmission to SSA. All Blue Cross queries pass through the Blue Cross Association central office in Chicago, Illinois. A temporary open item file is generated and is updated by replies from SSA, and reports of current eligibility are provided for forwarding to providers. Provider interim and final billings for inpatient services are first reviewed by intermediaries to check the propriety of treatment to the illness or injury or to exclude custodial treatment. They are then batched and processed through batch balance, reformat and edit programs. Records are passed on to an automated payment approval operation which calculates payments on a per diem, "charge" or PIP basis. (Checks are prepared by the individual plans' automated payment process.) A master history of transactions is established and maintained, and a payment data report tape is also generated and mailed to SSA for update and control purposes.

A separate operation within the model system processes provider requests for payment of outpatient services. Billing forms are batched, entered into the system, balanced, edited and prepared for querying SSA. As above, payment amounts are calculated, a master history of transactions is maintained and a payment record tape prepared for transmittal to SSA.

The Model A system provides several reports useful to management on open items, errors and edits, and provider profiles. There are also several optional subsystems available to Model A system

CHART 13: PART B MODEL SYSTEM



users. Three deal with automated correction facilities: for HI claim number change, batch audit-return bills control and adjustments (debit/credit). Another two subsystems concern data reports: one on aging transactions and the second on paid claims. A sixth subsystem offers the facility for establishing and maintaining an automated provider file.

5. Part B Model System (Chart 13)

Like the intermediaries, the carriers have various types of systems for processing Part B (medical) benefit requests for payment. About 45 percent use the Part B model system, a package of program modules for automatically processing payment requests.[10/] Other Part B processing systems use similar methods to process Part B Medicare claims.

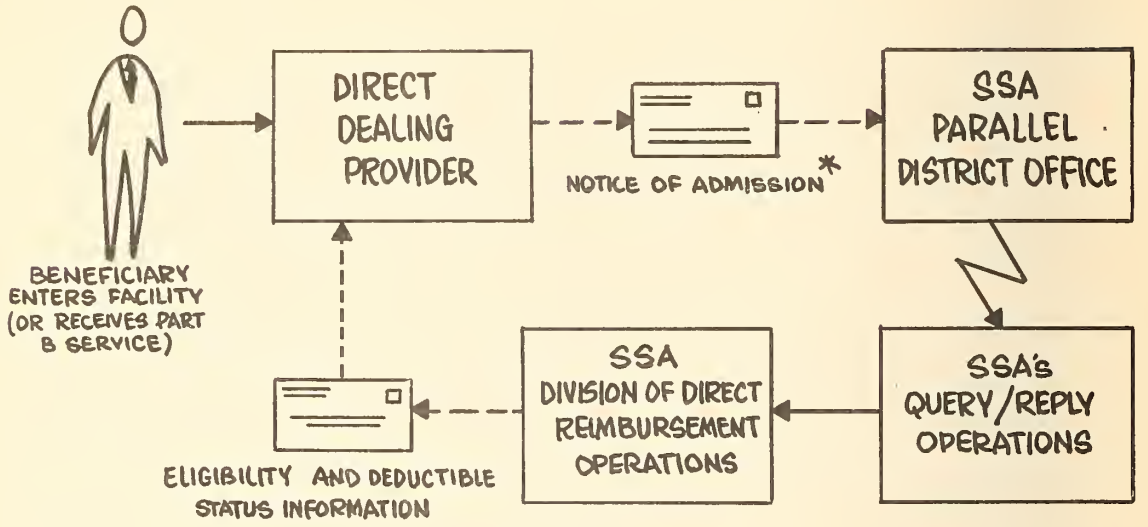
Under the Part B model system, incoming benefit payment requests from either physicians or suppliers of services or beneficiaries themselves are assigned a control number which stays in the system until processing of the payment request has been completed. The record may then be passed to an optional operation for checking against a file of prior claims for utilization information or for detecting an overpayment situation. The records move on to an edit program (which also generates turnaround cards for correction of the erroneous conditions, and reentry) and subsequently to a pricing operation. The latter prices individual items on the payment request against screens and, with an optional feature, can automatically reduce the charge shown to the predetermined reasonable charge. This information is then passed to the history module operation which stores the transaction, checks for duplicates and determines the need to query SSA. Data from this file are also used to generate provider reasonable charge profiles and for the detection of potential abuse or fraud in payment cases.

The model query/reply operations query SSA on benefit eligibility and deductible status, where appropriate, and apply the information received in reply to the current transaction. In the succeeding data disposition operation, benefits are calculated, payment is made and notices are prepared for physicians/suppliers and beneficiaries. The control and history files are updated with the transaction, and payment records are generated for SSA. A final module reconciles the check register; accounts for monies disbursed and received and for expenses incurred; prepares the payment records for transmission to SSA; and maintains a pending file of SSA rejects, over- and under-payments and payment record changes.

10/ These model system carriers handled about 25% of total claims processed and 28% of the total carrier-processed benefits paid out during fiscal year 1973.

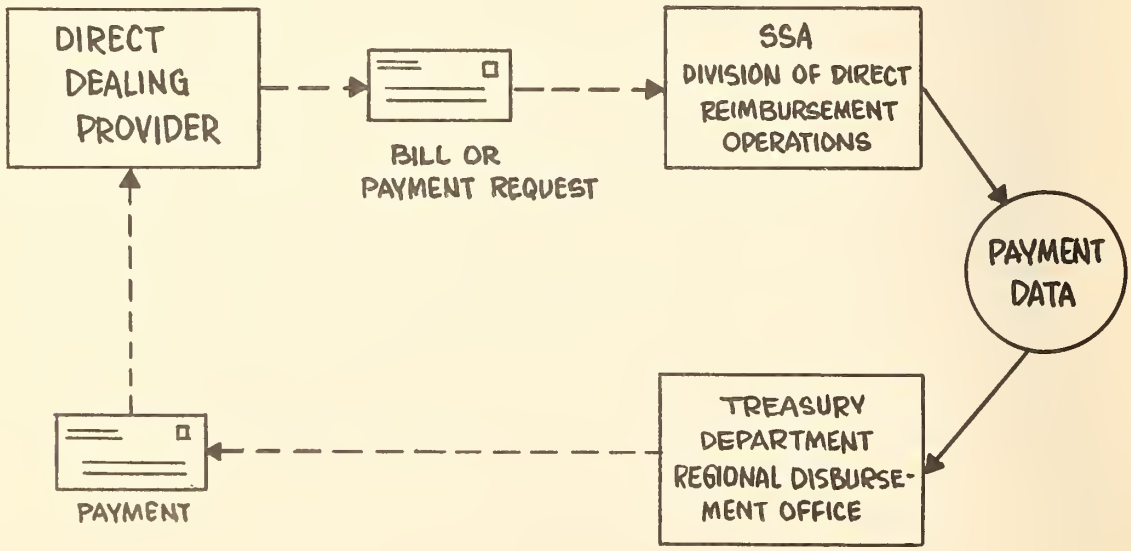
CHART 14: DIVISION OF DIRECT REIMBURSEMENT OPERATION

I. NOTICE OF ADMISSION



*SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES MAIL ADMISSION AND START OF CARE NOTICES DIRECTLY TO DDR, WHICH QUERIES HI SYSTEM

II. BILL PAYMENT



An on-line option and an Optical Character Recognition option are also available for the Model B system which provide for the direct keying or reading of payment requests into the computer process and replace a number of the above steps with more direct methods for controlling and editing of transactions.

6. Division of Direct Reimbursement (Chart 14)

The Bureau of Health Insurance's Division of Direct Reimbursement (DDR) acts as the intermediary/carrier for hospitals, skilled nursing facilities and home health agencies electing to deal directly with SSA. About 3% of all participating providers are direct dealing, and most (about 80%) are State or municipally controlled. DDR also serves as intermediary to federally funded comprehensive health centers and to over 400 Federal hospitals which participate in the program as Federal emergency hospitals.

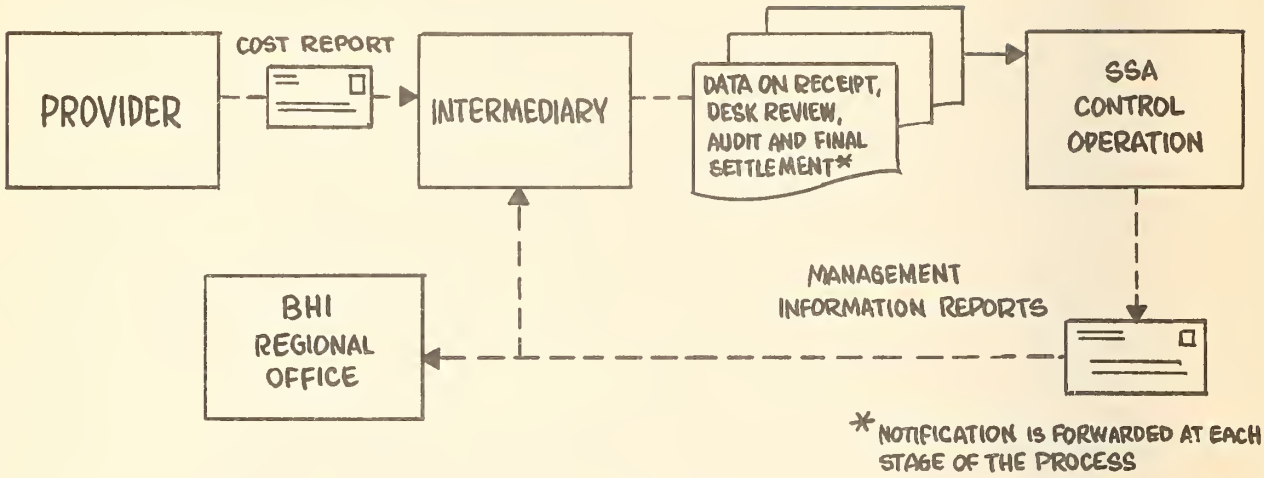
District offices parallel to the direct dealing provider facilities receive and review inpatient admission notices, then transmit the information to central office. Skilled nursing facilities and home health agencies mail admission and start of care notices directly to DDR. All subsequent inpatient billings and Part B billings are sent directly to DDR, which prepares Part B queries to the HI system and also mails all eligibility and deductible status replies to providers.

Direct dealing provider transactions are processed routinely through the query/reply and HI Beneficiary Master Update operations but other special DDR operations handle bill edit/balancing, control and payment processing and produce statistical reports for management relating to DDR transactions.

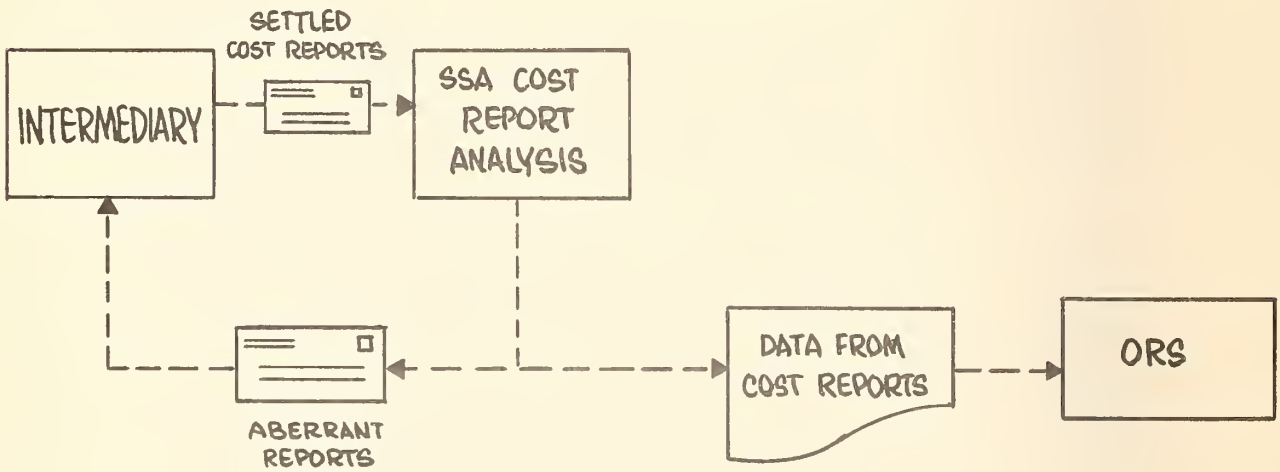
A separate master file of direct dealing providers with identifying information and payment rates is maintained for use in the edit and payment processing operations. Bills entering the DDR system are edited for consistency and are checked against the Direct Dealer Part A or Part B Master files for a match (to the previous query) or for duplicates. (Batches and individual bills (including returned bills) are controlled until each bill has been cleared.) Provider bills are screened electronically against guides for correct diagnostic codes, length of stay and other features to help DDR determine if services are medically necessary and reasonable to treatment of the illness or injury. Accepted records are passed on to the payment operation which uses the Direct Dealer Provider Master to calculate reimbursement amounts and to prepare tapes for Treasury use in preparing checks for providers

CHART 15: PROVIDER COST REPORTS

I. PROVIDER COST REPORT MONITORING SYSTEM



II. PROVIDER COST REPORT ANALYSIS



and beneficiaries. Notices of utilization are generated for mailing to beneficiaries. A paid bills file is also generated for entry into the SSA bill and payment record control operations and for subsequent updating of the HI master record. A monthly operation also updates a master file of bills paid by DDR and prepares a tape record for microfilming.

Like intermediaries outside SSA, DDR processes provider cost reports and determines final settlement amounts.

J. Provider Cost Reports

1. Reports Control (Chart 15-I)

In order that interim reimbursements can be adjusted to actual costs incurred, providers reimbursed by intermediaries on a reasonable cost basis are required to submit an annual cost report to the intermediary within three months following the provider accounting year. The intermediary conducts a comprehensive review of the report, determines whether or not to schedule a field audit of the provider and makes a final cost settlement. Beginning with the provider's filing of the cost report, the intermediary reports to SSA regularly on its activity through each step of the process: desk review, field audit and settlement. This enables SSA to measure the timeliness of provider filing of cost reports as well as to evaluate intermediary performance in report processing.

SSA's Automated Provider Cost Report Monitoring System provides intermediaries and BHI regional and central office staffs with information on provider cost report processing. More specifically, it identifies, by intermediary and provider, overdue cost reports as well as cost reports undergoing desk reviews and audits.

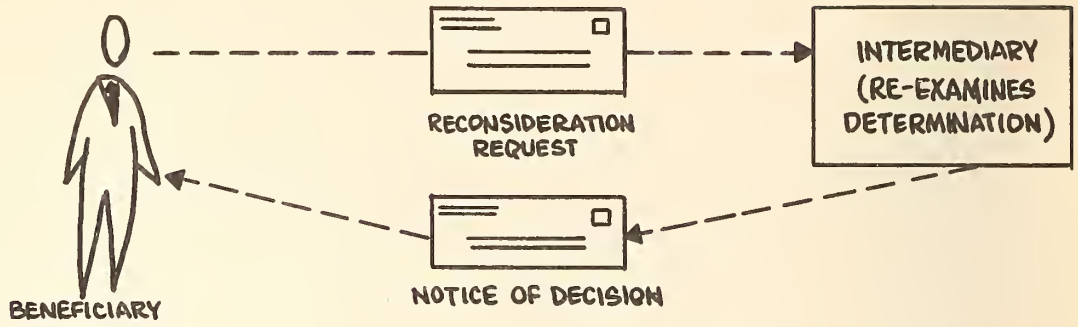
Other management information on cost reports is generated on a monthly or quarterly basis to help central office components monitor overall intermediary performance and evaluate audit policy effectiveness.

2. Reports Analysis (Chart 15-II)

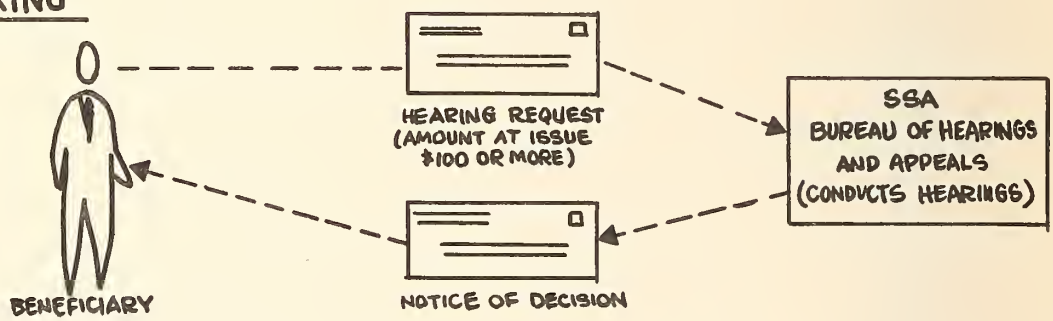
Cost reports and related (review and audit) materials submitted to SSA are reviewed clerically and selected data are extracted for a data collection and reporting system. Aberrant cost reports are identified for possible analysis. Where analysis reveals questionable items or costs, reports are referred to the intermediary for investigation and, where appropriate, adjustment. The data accumulated in the above review are also used by the Office of Research and Statistics in reporting on HI program costs.

CHART 16: THE APPEALS PROCESS - PART A BENEFITS

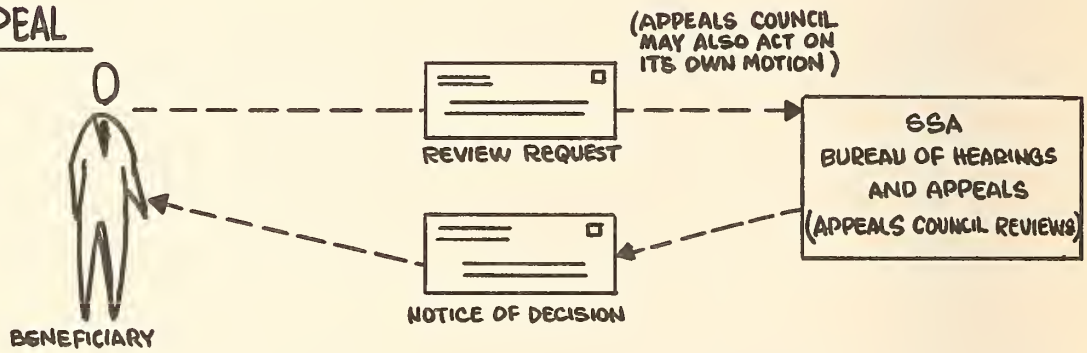
I. RECONSIDERATION



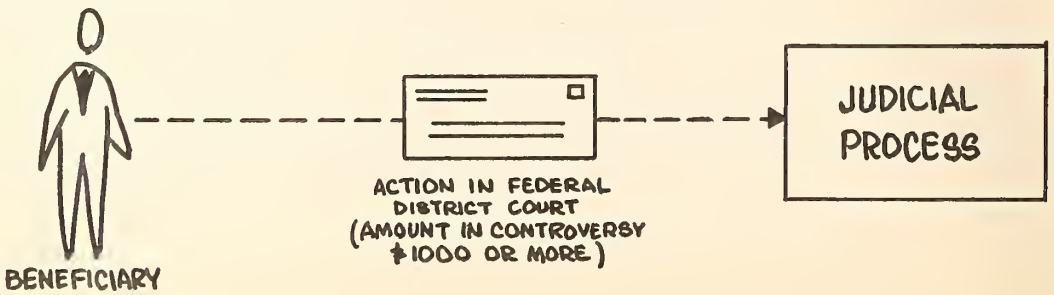
II. HEARING



III. APPEAL



IV. JUDICIAL PROCESS



K. Appeals Process

1. Beneficiaries

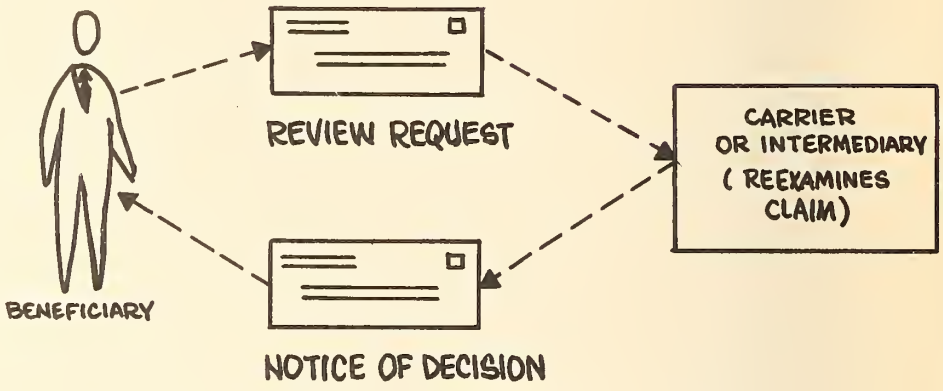
Part A (Chart 16)

Individual beneficiaries may appeal Part A inpatient and Part B medical insurance benefit amounts determined by intermediaries and carriers. In the case of Part A benefits, reconsideration is the first step in the formal appeals process. Any written statement by the beneficiary or his authorized representative expressing disagreement with the determination of the benefit amount (or requesting a review of the case) constitutes a request for reconsideration. The intermediary which made the initial determination on the contested benefit (or denial of benefit) handles the individual's reconsideration request. Any additional documentation needed to clarify issues is secured; a full review of the original determination is made by an individual other than the one making the original determination and the enrollee notified of the resulting decision. If the individual is still dissatisfied, he may appeal the decision further if the amount in controversy is $100 or more. This second step in the appeals process is a hearing, and is handled by SSA's Bureau of Hearings and Appeals. As the third step, the Bureau's Appeals Council may review a hearing examiner's decision either on its own motion or at the request of the beneficiary. The beneficiary may bring action in Federal district court if he is still dissatisfied and the amount in controversy is $1,000 or more.

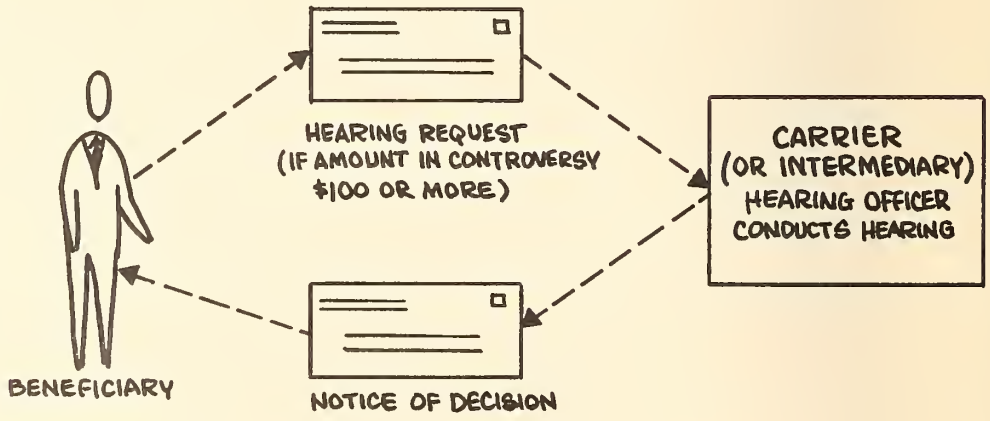
Beneficiary Part A appeals at each stage are controlled electronically by the Reconsideration Control and Management Information System. DO's or intermediaries receiving requests for reconsideration furnish copies of requests to BHI's Reconsideration Branch. The branch introduces this and further appeal information into the control operation where on a weekly basis it is edited for consistency and sorted for preparation of data reports. Weekly, monthly and quarterly reports giving case listings, workload status and profile data are generated for use by the Reconsideration Branch and the Bureau of Hearings and Appeals.

CHART 17: THE APPEALS PROCESS - PART B BENEFITS

I. RECONSIDERATION (REVIEW)



II. HEARING (NO FURTHER APPEAL)



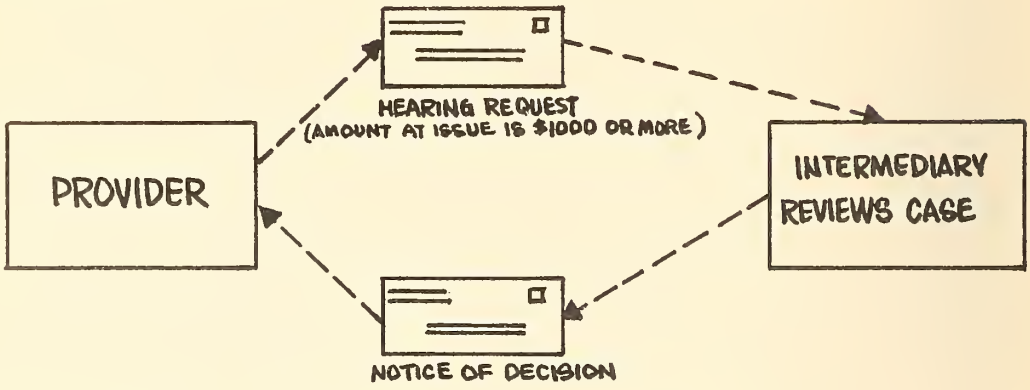
Part B (Chart 17)

In the case of Part B appeals, carriers (or intermediaries making determinations on Part B services) handle both reconsideration reviews and fair hearings; an individual may appeal no further. Hearings are limited to cases where the amount in controversy is $100 or more.

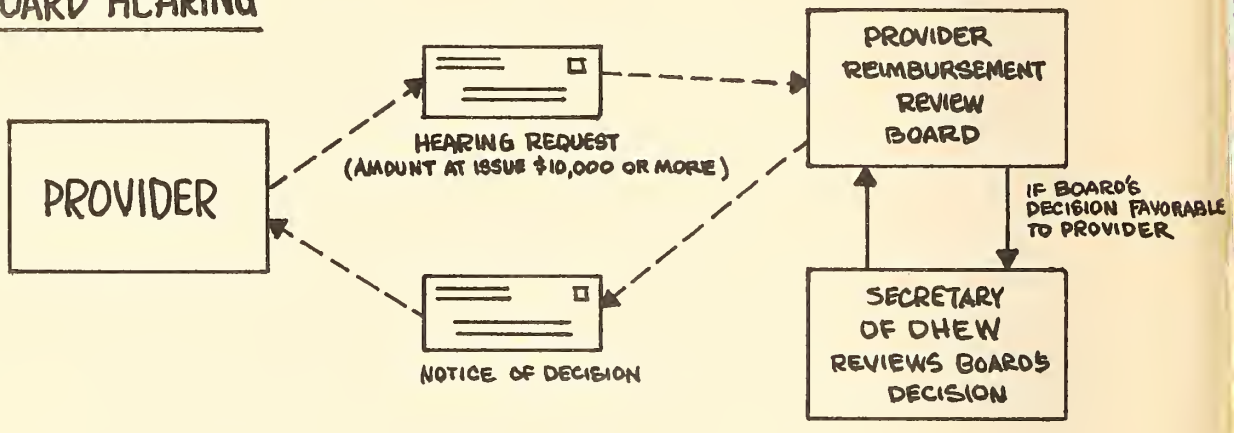
As with Part A, any written statement indicating disagreement with the carrier/intermediary decision is considered a request for review of the request for payment in question. The carrier or intermediary makes a new examination of the entire case (by an individual other than the one making the initial determination), obtaining additional evidence if necessary to clarify or complete the examination. The beneficiary is notified of the review decision and that he may request a fair hearing if he is still dissatisfied. The hearing is conducted by a hearing officer designated by the intermediary - an attorney or other individual qualified to conduct a formal hearing. The beneficiary is notified in writing of the decision.

CHART 18: THE APPEALS PROCESS FOR PROVIDERS (REASONABLE COSTS DETERMINATIONS)

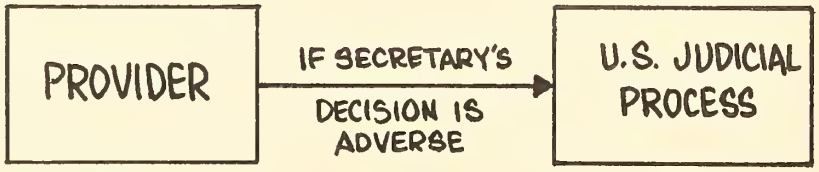
I. HEARING



II. BOARD HEARING



III. JUDICIAL REVIEW



2. Providers (Chart 18)

The providers of services can appeal both reasonable cost determinations and participation issues. A provider can request a hearing by the intermediary on the latter's determination of reasonable costs if the amount at issue is $1,000 or more. It can appeal further if the amount at issue is $10,000 or more. In these cases a Provider Reimbursement Review Board appointed by the Secretary conducts an evidentiary hearing. The Secretary can reverse or modify a Review Board's decision if the decision was favorable to the provider. If still dissatisfied with the decision, the provider is entitled to judicial review.

Providers can also appeal SSA determinations that the facility does not meet conditions for participating in the program. The BHI regional office handles the reconsideration determination. Further appeals through hearing, Appeals Council review and judicial review can be made by the provider.

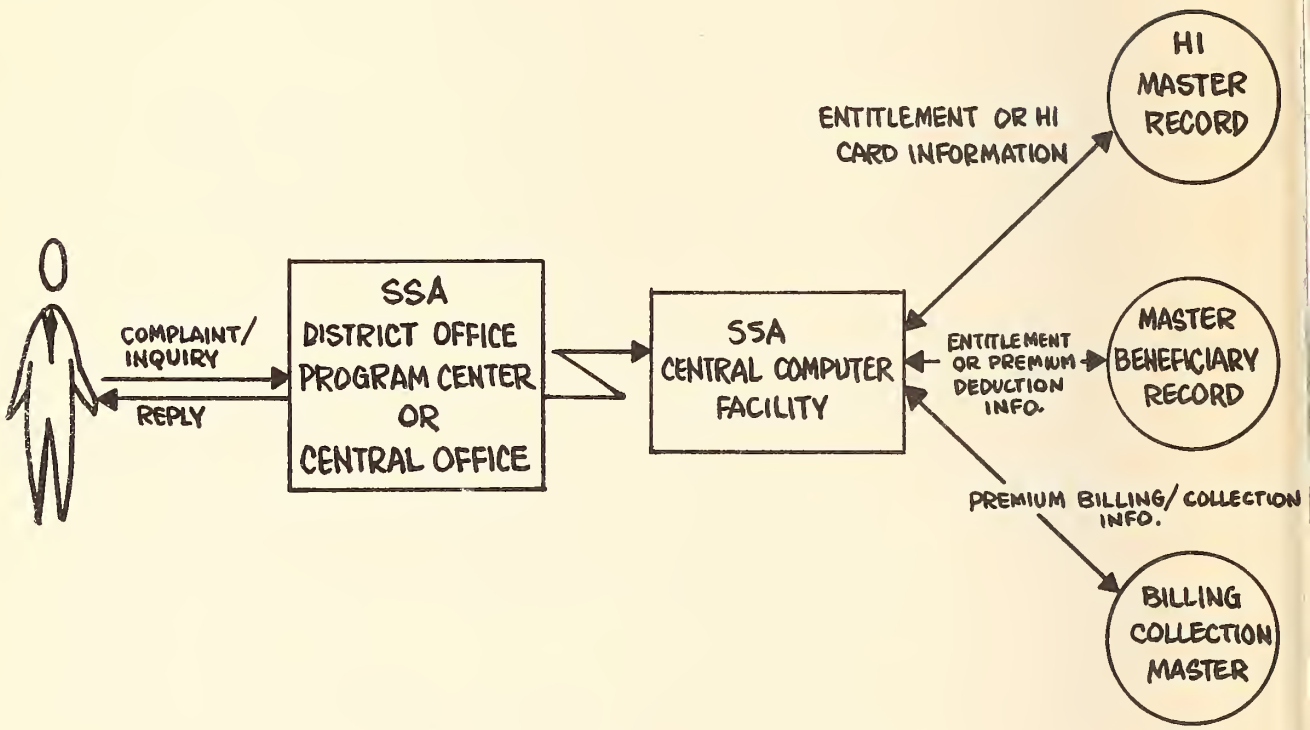
The 1972 Amendments provided a waiver of beneficiary and provider liability for payment of Part A claims for services that are not medically necessary or that are not at a covered level of care. The parties must also be without fault. Where the intermediary finds the provider liable, that is the provider did not exercise due care in applying Medicare policy, the provider can appeal the disallowance decision both as to covered services and "due care."

3. Carriers and Intermediaries

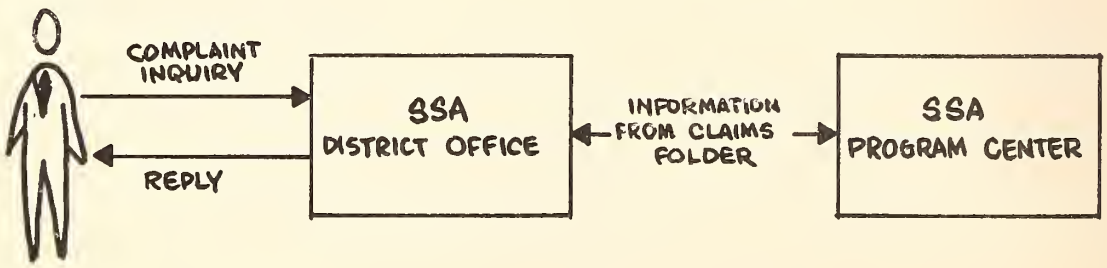
SSA may, for cause, terminate a carrier's or intermediary's contract with SSA, providing it gives it notice and an opportunity for a hearing before the Commissioner. If after the hearing, SSA determines that the contract should be terminated, the carrier or intermediary may request a review by the Secretary. The Secretary's decision is final; no further appeal is available.

CHART 19: BENEFICIARY COMPLAINTS/INQUIRIES

I. REFERRALS TO CENTRAL OFFICE (MASTER RECORDS)



II. REFERRALS TO PROGRAM CENTER (CLAIMS FOLDER)

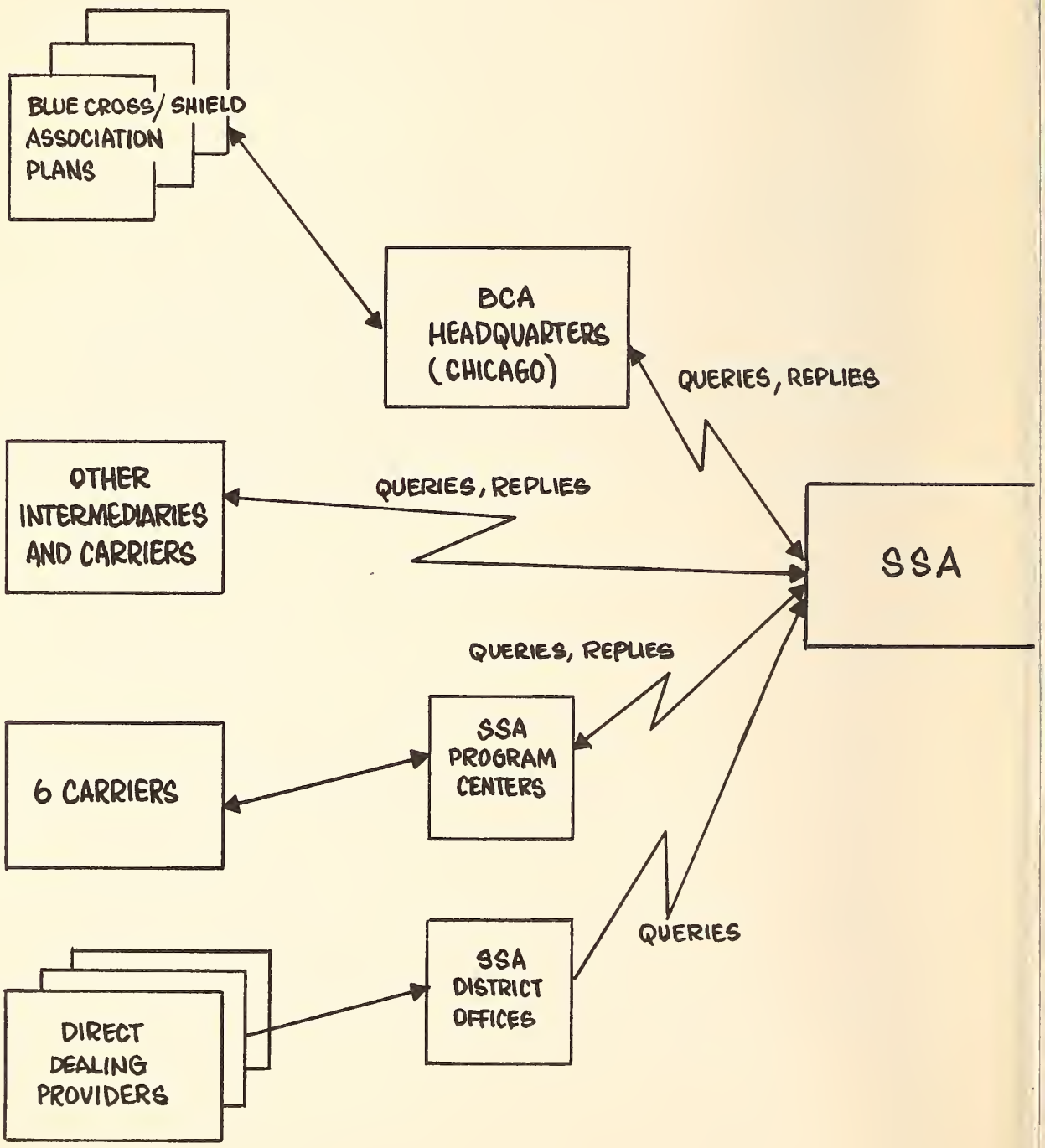


L. Complaints (Chart 19)

Health insurance beneficiary inquiries or complaints other than those about benefit payments, generally concern entitlement, SMI premiums - their billing and collection - or health insurance cards. The inquiries are usually directed to either the SSA district office or the program center. Both of these offices have access to the major records which provide the information necessary for resolving the inquiry or complaint. Information for entitlement or health insurance card problems is obtained by querying the MBR and HIMA. Premium problems usually involve a query to the MBR or the BCM.

District offices can query the above master file records directly. Often, however, they have information from the inquiry which does not coincide with the pertinent master record (e.g., a recent premium payment). In these cases they route inquiries to the program center for reference to the individual claim folder (in these cases master files have not yet been updated with the latest information). Requests for correction of the MBR or HI Master record are sent to the program center or BDP in central office, as appropriate. A special unit in the program center handles all health insurance inquiries and complaints. Special microfilm record files and exception records provide program center personnel with additional sources of "history" for the tracing of past transactions.

CHART 20: HEALTH INSURANCE TELECOMMUNICATIONS



M. Telecommunications (Chart 20)

The HI system relies on an extensive telecommunications system to receive and transmit intermediary, carrier and district office health insurance queries and replies. SSA receives over 7 million queries monthly via teletype or high speed magnetic tape transmission lines. About 1/3 of all transmissions are from the Blue Cross Association's central facility in Chicago, Illinois. Over half of all queries are transmitted by intermediaries and carriers over private line, high speed tape circuits. A little less than 10 percent of the queries are transmitted by 6 carriers through three SSA program center facilities, and the balance of the queries (less than 5 percent) are sent by teletype. The latter represent SSA district offices querying for direct dealing providers, and a few carriers and intermediaries which use DO telecommunications facilities. The BCA transmissions are by high speed magnetic tape over a private dedicated line. (BCA's internal network is comprised of various means of transmitting information to the central facility.)

Blue Cross Association transmits queries for an average of 6 hours daily and intermediaries on private lines total about 29 hours daily. Teletyped messages are converted automatically to magnetic tape. BDP's Data Transmission Branch then furnishes tapes to the electronic data processing operation daily and output is returned on the following day for reply transmission to requestors.

Billing records and payment records are mailed to SSA. About 70% of Part A bills are on magnetic tape and all Part B payment records are on magnetic tape. The balance of Part A bills are hard copy.

GLOSSARY

BCM - The Billing and Collection Master record contains data on beneficiaries who must be billed directly (they either receive no benefits or are not in current payment status). The SOBER system maintains the file.

Benefit Period - A period of time for measuring use of hospital insurance benefits. It begins on the entitled beneficiary's admission to a hospital or other facility and ends after the 60 consecutive days during which the individual was not an inpatient of any hospital or skilled nursing facility.

Carrier - A private or public organization with which SSA enters into agreement to help administer the Part B benefits under the health insurance program. Also referred to as "contractors", the carriers determine medical benefit amounts payable and make payment to physician/suppliers or beneficiaries.

Claims System - The system which processes claims applications for retirement, survivors, disability and health insurance (only) entitlement. It locates earnings records, computes benefits and prepares documents for the claims file. On completion of the claim processing it establishes new beneficiary records and prepares transcripts for Treasury Department check printing operations.

Coinsurance - A percentage of the total HI benefit amount, on a bill or request for payment, payable by the insured beneficiary. Under Part B, the beneficiary pays 20 percent of the allowed (reasonable) charges after he has met the deductible. Under Part A, the beneficiary pays a $21 per day coinsurance amount for the 61st through the 90th day of inpatient care. (Applicable to 1974 calendar year.)

Cross-Reference - A claim number related to the current number. In cases where an individual becomes entitled under a new number (for example a woman formerly entitled under her husband's number becomes entitled under her own number), the actions under both are recorded under the current (new) number.

Deductible - A stipulated amount which must be exceeded with covered services before HI benefits are payable. The Part A deductible is $84 for each benefit period; the Part B deductible is $60 (applicable to the 1974 calendar year).

GEP - The General Enrollment Period is an open season period between January 1 and March 31 each year for enrollment of individuals who missed initial enrollment, were terminated or cancelled coverage voluntarily. (This procedure applies to Part B and premium Part A coverage.)

Group Health Plans - Organizations which provide member health service on a non-fee-for-service basis. One type, the Group Practice Prepayment Plan, provides medical services only. The Health Maintenance Organization provides both hospital and medical services to members. Under both types of plans, members pay monthly premiums to the plan to cover costs of services.

HI Card - The 2" x 3" card issued to health insurance beneficiaries for presentation to providers of health services. In addition to name, claim number, and sex, the card shows entitlement to hospital and/or medical insurance and the effective date of entitlement.

HIMA - The Health Insurance Master record is the basic social security file of all individuals entitled to Part A or Part B benefits or both.

Interim Rate - The basis for the intermediary's ongoing, temporary reimbursement to providers of services. The rate is determined by the intermediary as a percent of the billed charges or as the average per diem amount based on estimated cost of the services. The reimbursement is adjusted after the close of the provider's fiscal year, when the provider files a cost report and the intermediary performs a comprehensive review and possibly an audit of the report.

Intermediary - A private or public organization with which SSA enters into agreement to help administer Part A benefits under the health insurance program. The intermediaries determine costs for Part A benefits and make payment to providers.

MBR - The Master Beneficiary Record is the basic social security file of all retirement, survivor, disability and health insurance beneficiaries.

Open Item - A record of admission to a hospital or facility for which a discharge bill has not been received or processed.

PE System - The post-entitlement system handles all post-claims actions on beneficiary accounts. Among the many functions the extensive operations comprising the system perform are updating the MBR, adjusting benefit (or premium) amounts, and preparing folder documentation and beneficiary notices.

PIP - The Periodic Interim Payment is a type of interim payment which furnishes providers with reimbursement for services more quickly than other arrangements. Intermediaries make payment weekly, generally, based on a per-inpatient-day rate calculated on estimated cost for the services provided.

Provider - Any individual or organization furnishing Part A health services to Medicare beneficiaries. Hospitals, skilled nursing facilities, home health agencies are examples of providers.

Provider Master File - A file which contains bill charges and reimbursements made, arranged by provider.

Reasonable Charge - The rate for a medical service determined by a carrier for reimbursement to physicians/suppliers or beneficiaries. The amount is based on two standards provided by the law; the physician's (or supplier's) customary charge for furnishing the service and the prevailing charge for the service in the locality.

SOBER - The Separate Operation for Billing, Entitlement and Remittances is the system which handles premium billing and remittances for beneficiaries not in benefit status and who do not have a third party payer. The system also identifies individuals for termination of coverage where premiums have not been paid.

Third Party Master - A file of all health insurance beneficiaries whose premiums are paid by a third party: a State, the Civil Service Commission or a private organization.

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